Filing at a Glance

Company:	Community Health Alliance Mutual Insurance Company
Product Name:	CHA Small Group
State:	Tennessee
TOI:	H16G Group Health - Major Medical
Sub-TOI:	H16G.003G Small Group Only - Other
Filing Type:	Form/Rate
Date Submitted:	06/13/2013
SERFF Tr Num:	CHAM-129072687
SERFF Status:	Assigned
State Tr Num:	H-130573
State Status:	Assigned - Pending Review
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Cannon Witt
Reviewer(s):	Vicky Stotzer (primary), Brian Hoffmeister, Melissa Merritt
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

SHOP P

ETN_100_EPO_14

SHOP exchange small group policy

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*

TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 06/14/2013
State Status Changed: 06/14/2013
Created By: Cannon Witt
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 05/01/2013
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Cannon Witt

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:
Community Health Alliance Small Group 2014 Filing

Company and Contact

Filing Contact Information

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Filing Company Information

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445 S Gay Street
Knoxville, TN 37902
(888) 415-3332 ext. [Phone]

CoCode:
Group Code:
Group Name:
FEIN Number: 45-3127905

State of Domicile: Tennessee
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Correspondence Summary

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Group EOC OutofNetwork	Cannon Witt	06/14/2013	06/14/2013
Form	Group POS Schedules	Cannon Witt	06/14/2013	06/14/2013
Rate	CHA Group On Exchange Rates	Cannon Witt	06/14/2013	06/14/2013
Supporting Document	Modified Plan and Benefits	Cannon Witt	06/14/2013	06/14/2013

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Amendment Letter

Submitted Date: 06/14/2013
Comments:
Change for split between on/off exchange.
Changed Items:

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Group EOC OutofNetwork	ETN_100_POS_14	POL	Initial		40.000		Date Submitted: 06/14/2013 By:
Previous Version								
1	*Group EOC OutofNetwork*	*ETN_100_POS_14*	*POL*	*Initial*		*40.000*	*TN Group EOC OON Final.pdf*	*Date Submitted: 06/13/2013 By: Cannon Witt*
2	Group POS Schedules		SCH	Initial		0.000		Date Submitted: 06/14/2013 By:
Previous Version								
2	*Group POS Schedules*		*SCH*	*Initial*		*0.000*	*Group POS Schedules.pdf*	*Date Submitted: 06/13/2013 By: Cannon Witt*

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	CHA Group On Exchange Rates	ETN_100_EPO_14	New		CHA Group_OnExchange_SERFF Format.xls,	06/14/2013 By:
Previous Version						
1	*CHA Group Rates*	*ETN_100_EPO_14, ETN_100_POS_14*	*New*		*CHA Group_SERFF Format.xls,*	*06/13/2013 By: Cannon Witt*

Supporting Document Schedule Item Changes

Satisfied - Item:	Modified Plan and Benefits
Comments:	Modified not needed for On Exchange
Attachment(s):	
Previous Version	
Satisfied - Item:	*Modified Plan and Benefits*
Comments:	
Attachment(s):	*ModifiedPlanandBenefitChart_Group_OffExchange.xlsx*

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group EOC InNetwork	ETN_100_EPO_14	POL	Initial		40.500	TN Group EOC Final.pdf
2		Group EOC OutofNetwork	ETN_100_POS_14	POL	Initial		40.000	
3		Group EPO Schedules		SCH	Initial		0.000	Group EPO Schedules.pdf
4		Group POS Schedules		SCH	Initial		0.000	

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

EVIDENCE OF COVERAGE AND SUMMARY PLAN DESCRIPTION

IN-NETWORK GROUP BENEFIT PLAN

COMMUNITY HEALTH ALLIANCE MUTUAL INSURANCE COMPANY

PLEASE READ THIS EVIDENCE OF COVERAGE AND SUMMARY PLAN DESCRIPTION CAREFULLY. KEEP IT IN A SAFE PLACE. IT EXPLAINS YOUR COVERAGE FROM COMMUNITY HEALTH ALLIANCE. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OR WRITE CUSTOMER SERVICE, OR YOU MAY VISIT OUR WEBSITE AT: www.chatn.org

COMMUNITY HEALTH ALLIANCE
MUTUAL INSURANCE COMPANY
445 S. GAY ST. SUITE 101
KNOXVILLE, TN 37421
865-862-4164

THIS IS ONLY A SUMMARY

This Evidence of Coverage and Summary Plan Description ("EOC") is part of the Group Agreement between Community Health Alliance and Your Group. This EOC describes the terms and conditions of Your coverage from the Plan through the Group. It replaces any EOC that You previously received from the Plan.

Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not covered by the Plan. Other Covered Services are limited unless pre-approved by the Plan. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that non-covered service.

The Group has given authority to the Plan to make any benefit or eligibility decisions. It has also granted the Plan authority to construe the terms of Your coverage under the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such decisions.

Please contact a Customer Service representative at the number listed on Your membership ID card if You have any questions regarding this EOC or any other matters related to Your coverage from the Plan.

The benefits described in this EOC are referred to as "the Health Plan," or simply "the Plan."

PLAN TERMS

This EOC describes the Plan as of January 1, 2014.

RIGHT TO AMEND OR TERMINATE

The Plan has the right, at any time, to amend or terminate the Plan, as described on page 54 in the *General Information* section of this EOC.

MODIFICATIONS NOT PERMITTED

No one can change or modify this EOC or other legal documents describing the Plan, either orally or by informal emails other unofficial mailings. The Plan can only be modified by official Plan amendments.

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ELIGIBILITY AND ENROLLMENT

WHEN COVERAGE BEGINS AND ENDS

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY

If You're part of this group…	You are eligible to participate in the Plan if …
Employee	You are a full-time salaried employee as defined by the Plan Sponsor.

EXCLUSIONS

Independent contractors, leased employees, and any persons shown on the records of the Plan Sponsor as independent contractors or leased employees are not eligible to participate in the Health Plan.

No person is eligible to re-enroll in the Plan if the Plan previously terminated his or her coverage for cause.

DEPENDENT ELIGIBILITY

If You are eligible for coverage, You may also cover Your Eligible Dependents under the Plan. Social Security numbers are required for enrollment of all dependents. Eligible Dependents are:

- Your spouse. Your spouse is Your current husband or wife as recognized by Tennessee law.
- Your Domestic Partner. Tax consequences may exist for coverage of Domestic Partners.
- Your children 26 and younger

  Your children are:

  - Your natural or lawfully adopted children (including children placed for adoption), stepchildren and persons for whom You are the legal guardian; and
  - Children for whom You are responsible for coverage under the terms of a court decree a Qualified Medical Child Support Order (a QMCSO).
- Your unmarried children over age 26 who are unable to support themselves because of a permanent mental or physical handicap and are dependent on You for support and maintenance, and are considered dependents for income tax purposes. These children must have been covered by this Plan prior to reaching age 26. You must provide proof of the child's disability to the Plan within 31 days after his or her coverage would end. Thereafter, You must provide proof of the disability once a year after the two year period following the child reaching age 26.

Individuals who permanently live outside the United States are not eligible for coverage under this Plan.

The Plan's determination of eligibility under the terms of the Plan is final.

The Plan reserves the right to require proof of eligibility including, but not limited to a certified copy of any QMCSO or certification.

HOW TO ENROLL

You will receive information on how to enroll. You will use the benefits election process to enroll in (or decline) the Plan. You must enroll within 31 days after You become eligible under the Plan. Also, You must enroll any Eligible Dependent(s) within 31 days after they become eligible to participate in the Plan.

PREMIUMS

You may be required to pay for some or all of the Premiums for coverage under this Plan. If You do not pay all of the Premium, the rest may be paid by the Plan Sponsor or, if applicable, Your Advanced Premium Tax Credit (APTC).

If You receive an APTC and have not paid Your Premium when due, you are entitled to a grace period of 3 months in a row to pay Your Premium. This grace period will apply only if You have paid a least one full month's Premium during the Plan Year. Coverage will continue during the first month of the grace period, but the Plan will suspend payment of claims for any Covered Services during the second and third months of the grace period if no Premium payments are made. If the grace period of 3 months ends without You paying all outstanding Premiums, coverage will end as set forth in the "When Your Coverage Ends" section below.

If You do not receive an APTC, You are entitled to a grace period of 31 days for payment of Your Premium, except for the first Premium due. Coverage will continue during the grace period, unless You provide the Plan with written notice of prospective cancellation in accordance with the terms of the Plan. You may be liable for a prorated Premium for coverage provided during the grace period.

You will be provided with written notice at least 31 days prior to the date any increase in Premium rate would become effective.

IF BOTH YOU AND YOUR SPOUSE ARE ENROLLED IN THE PLAN

Married couples may enroll in whatever combination of single or married coverage that meets their needs. However, under the same Plan Sponsor, no individual may be covered as both an individual and a dependent, and dependents cannot be covered by more than one individual.

ANNUAL ENROLLMENT: NEW EMPLOYEE

Your election to participate or not participate in the Health Plan will continue each year unchanged, unless You actively elect to change Your election during Annual Enrollment, at which time You may:

- elect coverage if You previously declined it; or
- elect a different Plan option.

Changes made during Annual Enrollment are effective January 1st immediately following Annual Enrollment.

CHANGING YOUR COVERAGE

Because of the tax advantages that apply to the Plan, federal laws restrict Your ability to change Your elections once they are effective. These laws govern the types of changes that You may make during the Plan Year. In general, once You enroll for (or decline) coverage, Your benefit elections and Covered

Dependents stay in effect until You change them at Annual Enrollment.

However, under certain circumstances, You may enroll in the Health Plan or add or remove Covered Dependents during the Plan Year. Except as allowed, You cannot change from one coverage option to another. If You have an event permitting a mid-year change, You may make changes to any of Your elections, subject to certain exceptions and limits explained below.

CONSISTENCY RULE

For change in status elections under the Health Plan, any change in election must affect eligibility under the Health Plan. In addition, regardless of what event You have, any election change You make must be because of and consistent with the event. For example, You can elect to cover Your spouse following Your marriage or Your child following an adoption.

The Plan Administrator, in its sole discretion, will determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

ELECTION PERIOD FOR CHANGING COVERAGE AND EFFECTIVE DATE OF COVERAGE

If You have an event permitting You to change Your Health Plan coverage, You must notify the Plan and make Your election changes within 31 days of the event. If you do, coverage changes made due to a mid-year event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are generally effective as of the date of the event. However, for HIPAA special enrollment of a child as the result of birth, adoption or placement for adoption, coverage will be effective as of the date on which You acquire the child.

If You do not make an election on time, You will not be able to make a mid-year election and will have to wait until the next Annual Enrollment to make any election changes.

CHANGE IN STATUS

You can change Your Health Plan coverage during the year if a change in status occurs that affects eligibility for coverage under the Plan or under another employer's group health plan (such as the plan of a Dependent's employer). A change in status is any of the following:

- Your marriage, divorce, legal separation or annulment;
- the birth, adoption, or placement for adoption of a child;
- a change in Your spouse's job or involuntary loss of health coverage under another employer's plan (other than coverage under the Medicare or Medicaid programs);
- the death of an Eligible Dependent;
- Your Dependent child no longer qualifies as an Eligible Dependent;
- a change in Your or Your spouse's position or work schedule that affects eligibility for health coverage;
- a strike or lockout involving You or Your Spouse; or
- a court or administrative order.

Note: Any child under age 26 who is placed with You for adoption will be eligible for coverage on the date the child is placed with You, even if the legal adoption is not yet final. If You do not legally adopt the child, all Plan coverage for the child will end when the placement ends. There will be no continuing coverage (such as COBRA coverage) for the child.

CHANGE IN FAMILY STATUS EXAMPLE

Jane is married and has two children who qualify as Eligible Dependents. At Annual Enrollment, she elects not to participate in the Plan, because her husband, Tom, has coverage for her and the children under his employer's medical Plan. In June, Tom loses his job. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect to add her Eligible Dependents under the Plan outside of Annual Enrollment.

HIPAA SPECIAL ENROLLMENT

Under HIPAA, You have the right to enroll Yourself and Your Eligible Dependents for medical coverage, even if You were not already enrolled, within 31 days after the following special enrollment events:

- You declined medical coverage because You or Your Dependent had other coverage as stated in writing as the reason for declining coverage in this Plan and the other coverage ends because:
  - You or Your Dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);
  - You or Your Dependents exhaust COBRA coverage under another employer's group health plan (other than due to a failure to pay Premiums or for cause); or
  - Employer Premiums toward the other group health plan coverage end.
- You acquire a Dependent as a result of a marriage, birth,

adoption, placement for adoption, or appointment of legal guardianship. Coverage for a Dependent child will be effective from: the moment of birth; the date of adoption or placement for adoption; and the moment the child is placed in Your physical custody as legal guardian. If the child is not enrolled within 31 days from the date You acquire the child and an additional Premium is required, the Plan will not cover the child after the 31 days.

- You or Your Dependent lose coverage under Medicaid or a state child health Plan under Title XXI of the Social Security Act, or You or Your Dependent gains eligibility for Premium subsidy assistance under Medicaid or a state child health plan. In the case of loss of Medicaid or a state child health plan, if You timely enroll, coverage will take effect on the first day of the month following enrollment.

If You do not request the change within 31 days (60 days for loss of coverage under Medicaid or a state child health plan) of Your special enrollment event, You lose the right to enroll for that event. If You already have Plan coverage when a special enrollment right applies to You, You may elect to switch medical options.

ENROLLMENT PURSUANT TO A QMCSO

You, a custodial parent or a state agency may enroll Your Dependent child in health care coverage, under the terms of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, which is determined to be a (QMCSO). Alternatively, coverage for a Dependent child may be revoked if the QMCSO requires the spouse, former spouse or another individual to provide coverage for the child. Only the child who is eligible for coverage under a QMCSO may be enrolled for or dropped from coverage.

A Dependent child can be enrolled for health care coverage under a QMCSO only if any required Premiums are made paid This means that any required contribution amount you are required to pay for Your Dependent child's coverage will be withheld from Your paycheck unless a state agency pays the required contribution. In addition, coverage will be effective as soon as administratively possible following the Plan Administrator's determination that the order is valid.

An existing QMCSO may be revoked by a similar order. In this case, You may drop Your covered Eligible Dependent by contacting the Plan within 31 days of the new order. If the child is not Your Eligible Dependent when the new order is issued, coverage will automatically end.

MEDICARE OR MEDICAID ENTITLEMENT

If You, Your spouse or other Dependent becomes entitled to Medicare or Medicaid coverage, You can drop Plan coverage for Yourself or that person. In contrast, if You, Your spouse or other Dependent loses Medicare or Medicaid coverage, You may enroll for Plan coverage for Yourself or that person.

SIGNIFICANT COST OR COVERAGE CHANGES

A number of events come under this category, and are described below. Please note any change must be requested within 31 days of the event.

- The cost of coverage for a benefit option significantly increases or significantly decreases during the Plan year (including if the significant cost change occurs under Your spouse's employer Plan).

  The Plan Sponsor, in its discretion, makes a determination whether an increase or decrease is significant enough to trigger a right to make mid-year election changes. Any insignificant increases or decreases, as determined by the Plan Sponsor, in the cost of coverage will be made automatically.

  If cost for a coverage option in which You do not participate significantly decreases, You can make an election to participate in that coverage option. In contrast, if the cost for Your elected coverage option significantly increases, You can select another coverage option providing similar coverage. If no option provides similar coverage, then You can drop coverage.

- An event occurs that significantly decreases coverage or causes You to lose coverage under Your current coverage option.

  A significant decrease of coverage can include such things as a large increase in the deductible, the copay or coinsurance amounts, and results in an overall reduction in coverage.

  An event that may cause You to lose coverage can include such things as elimination of a coverage option.

  These events allow You to change Your coverage option to another coverage option providing similar coverage. If no similar coverage is available, then You may end coverage.

- A coverage option is added or becomes much better during the Plan year and You are eligible for it.

  In this event, even if You did not enroll for coverage, You can elect coverage under the new or better option.

- You or Your Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution.

  This event allows You or Your Dependent to enroll for coverage. Note that if You gain eligibility for group health coverage sponsored by a governmental or educational institution, You may not drop Your Health Plan coverage.

- The change corresponds with a change made by You or Your Dependent under another employer plan in the following circumstances:

  - If the annual enrollment period under the other employer Plan occurs at a different time of year than this Plan's Annual Enrollment and the other employer Plan has a period of coverage that is different than the calendar year period of coverage provided under the Health Plan; or

  - If the other employer Plan allows You or Your Dependent to change elections due to the reasons above (change in status, special enrollment, QMCSO, Medicare or Medicaid entitlement and major cost or coverage changes).

NON-DISCRIMINATION

Eligibility, including continued eligibility, will not be based on Your or Your Dependents health status or any of the following related factors:

- Health status;
- Medical condition, including both physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of domestic violence; or
- Disability.

You will not be required to pay a Premium which is greater than the Premium for a similarly situated individual enrolled in the Plan on the basis of any health status related factor of Yourself or Your Dependent, unless allowed by law.

WHEN COVERAGE BEGINS AND ENDS

WHEN YOUR COVERAGE BEGINS

Your coverage begins on the earliest of the following dates, subject to the Actively at Work Rule set out below:

- The date You become eligible, if You enroll on or before that date or within 31 days after that date;
- The first day of January of the year following the end of any Annual Enrollment Period during which You enroll; or
- The first day of the month after the Plan receives Your enrollment form.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

Your Dependents' coverage begins on one of the following dates:

- The date You become eligible to cover Your Dependents, if You enroll them within 31 days after that date;
- The date You acquire an Eligible Dependent by birth, adoption or placement for adoption, provided You make written application for the Dependent and agree to pay any required Premiums, within 31 days of the date of eligibility;
- The first day of the month following the date You acquire the Eligible Dependent (other than by birth, adoption or placement for adoption), provided You make written application for the Dependent and agree to pay any required Premiums, within 31 days of the date of eligibility;
- The date indicated in a QMCSO, if You enroll Your Dependent within 31 days of the court order; or
- January 1st of the year following the end of any Open Enrollment Period during which enrollment for the Eligible Dependent has been made.

ACTIVELY AT WORK RULE

If You are not Actively at Work on the date coverage would become effective, coverage for You and Your Covered Dependents will be delayed until the date You are Actively at Work. If You are not at work on the date coverage would become effective due to a health-related factor, You shall be treated as Actively at Work for purposes of determining eligibility.

WHEN YOUR COVERAGE ENDS

Your coverage under the Plan will end:

- On the date You no longer meet the Plan's eligibility requirements;
- On the date the Plan ends or is terminated;
- On the date You are terminated for cause due to the following: the Plan has not received the required Premium for Your coverage (the fact that You have paid a Premium to the Plan Sponsor will not prevent the Plan from terminating Your coverage if the Plan Sponsor fails to submit the full Premium for Your coverage to the Plan when due); You fail to make a required Member payment; You fail to cooperate with the Plan as required by this EOC; or You omit or provide incorrect or misleading information, or commit fraud against the Plan (this includes, but is not limited to permitting the improper use of Your membership ID card); or
- On the last date Your Premium is paid through.

In addition, if You receive an APTC and do not pay all outstanding Premiums by the end of your 3 month grace period, Your coverage will end on the last day of the first month of the 3 month grace period.

WHEN YOUR DEPENDENTS' COVERAGE ENDS

Coverage for Your Dependents ends on the earliest of the following dates:

- On the date Your coverage ends.
- On the date the Dependent no longer qualifies as an Eligible Dependent.
- On the date Your Dependent becomes covered as an individual.
- On the date indicated in a QMSCO.
- On the date the Plan ends or changes,

PAYMENT FOR SERVICES RECEIVED AFTER TERMINATION OF COVERAGE

If You receive Covered Services after Your coverage ends, the Plan may recover from You the amount it paid for such services, plus any costs of recovering such charges, including attorney's fees.

EXTENDED BENEFITS

If You are hospitalized on the date Your coverage ends, benefits for Hospital Services will be provided: for 60 days; until You are covered under another plan; or until You are discharged, whichever occurs first. This paragraph will not apply to Your newborn child if You do not apply for coverage for that child within 31 days following the child's birth.

THE
HEALTH PLAN

HIGHLIGHTS OF THE HEALTH PLAN

This EOC is a summary of the Plan. The EOC describes the Plan, as of January 1, 2014.

The Plan offers health services through a network of providers that have agreed to charge Members negotiated rates for health care. The specific services that are covered under the Plan, and the limits that apply, are described in this EOC. You are required to use an In-Network Provider for Covered Services, except in the case of an Emergency.

THE HEALTH PLAN

- lets **You** choose Your own In-Network Provider. You are required to use an In-Network Provider for all Covered Services except in the case of Emergency;
- covers qualifying preventive care services at 100% at a Network Provider (see the *Schedule of Benefits* for each Plan option for specifics);
- offers the added benefit of health resources to help You make informed decisions about Your family's health care purchases. For more information, visit www.chatn.org.; and
- contracts with providers who agree not to Balance Bill you for the difference between the amount they charge and the amount the Plan pays, except for any required Coinsurance, Copayments or Deductibles.

CHANGING COSTS

The Plan reserves the right to change Your cost of coverage annually. Generally, Premiums changes are announced each year during Annual Enrollment.

Please read this EOC thoroughly to learn how the Health Plan works.

If you have questions, please call Customer Service at the number listed on your Plan ID card.

YOUR COSTS UNDER THE HEALTH PLAN

DEDUCTIBLE

The Plan may require You to satisfy an up-front Plan Year Deductible, as stated in the *Schedule of Benefits*, before the Plan begins to pay. The Deductible does not apply to certain preventive care services received from a Network Provider.

If You cover Yourself and Dependent(s), and one or more family members together incur Covered Expenses to meet the family Deductible, no further Deductible will be required from any family member for the rest of the Plan Year.

Copayments and any balance of charges are not considered when determining if You have satisfied a Deductible.

Note: The Deductible is sometimes referred to as *Member responsibility*.

COINSURANCE

Once You meet the Plan Year Deductible, the Plan pays the percentage, as shown in the *Schedule of Benefits*, for additional health care Covered Expenses. You pay any remaining percentage, which is Your Coinsurance.

COPAYMENTS

A Copayment is a fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

MAXIMUM OUT OF POCKET

The Maximum Out of Pocket (MOOP) is the most You will pay before the Plan begins to pay 100% of the cost of Covered Services for the rest of the Plan Year for a Network Provider other exclusions. Expenses paid to satisfy the Plan Year Deductible, Copayments, Coinsurance payments or any variation of these paid expenses will be used to meet the MOOP. Please see the Schedule of Benefits in the Exhibit to this Plan for details about Your Copayment and Coinsurance amounts. If You cover one or more family members, expenses for all of Your family members combined will apply to Your Plan Year family MOOP.

PREVENTIVE CARE SERVICES

Qualified Preventive Care Services are covered at 100% if received from a Network Provider**.** Qualifying preventive care services and benefits are covered with no Deductible, Co-payment, or Coinsurance.

For a complete list of qualifying preventive care services, see the section entitled, *Preventive Care Services – Schedule of Benefits* in the Exhibit. You may receive other preventive care services or choose to receive preventive care services from an Out-of-Network Provider; however, any such services will not be covered or may be considered as any other claim.

BALANCE BILLING

Network Providers should not Balance Bill You for Covered Services. This means that You should not have to pay for the difference between what they charge and what the Plan pays, except for any required Coinsurance, Copayments or Deductibles

HEALTH RESOURCES

IMPORTANT INFORMATION ABOUT THE MATERIAL FOUND IN THIS SECTION

Information obtained through the services identified throughout this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information you receive from these services is intended to help you make better health care decisions.

The Plan is not responsible for the results of any decisions You make from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text of the current medical literature.

PATIENT SUPPORT

The goal of the care management program is to support Your health care needs and educate You about Your benefits and available resources.

Nurses provide a variety of different services to help You and Your covered family members receive appropriate medical care. The Program requirements are subject to change without notice. Services may include:

- **Admission counseling** – For upcoming inpatient hospital admissions, a health coach may call You to answer questions and to make sure You have information to support Your recovery.
- **Inpatient care advocacy** – If You are hospitalized, a health coach may work with Your treatment team to make sure You are getting the care You need and that Your treatment plan is being carried out effectively.

Transition of Care – After leaving the hospital You may receive a phone call from a nurse if You have certain chronic or complex conditions. This program serves as a bridge for improved coordination of care between facility to facility or home transfers or facility to home. The nurse will also confirm Your medications, any required equipment, and make sure that follow-up services are in place.

If You do not receive a call from a nurse but feel You could benefit from any of these programs, please call Customer Service at the number listed on Your Plan ID card.

PREAUTHORIZATION

Some services require prior authorization from the Plan. Your Provider must get this prior authorization. If Your Provider fails to obtain prior authorization, Your claim for benefits may be reduced or denied. The services and devices for which Your Provider is required to obtain prior authorization include, but are not limited to:

- Observation in a hospital
- All non-emergent inpatient admissions, including:
  - Inpatient rehabilitation facility
  - Skilled nursing facility (up to 30 days if medically necessary)
  - Mental health
  - Substance abuse facilities
- Purchased durable medical equipment over $500
- All rented durable medical equipment.
- Home care services including infusion therapy
- Orthopedic footwear, shoe modifications and additions when costs exceed $300
- Some surgical/interventional services performed in an outpatient hospital or ambulatory surgery setting including but not limited to:
  - Chemotherapy
  - Cosmetic procedures
  - Dental, jaw and face procedures
  - Dental/oral surgery requiring general anesthesia
  - Oral pharynx procedures
  - Nuclear cardiology tests
  - Abortion
  - Hysterectomy
  - Genetic testing
  - Hyperbaric oxygen therapy
  - Infusion Centers
  - OB ultrasounds exceeding three per pregnancy
  - Pain management programs including epidurals, nerve blocks, facet injections, pain management pumps, dorsal column stimulators
- Chiropractic services after the tenth visit in a calendar year
- Physical therapy after the tenth visit in a calendar year
- Occupational therapy after the tenth visit in a calendar year
- Speech therapy after the tenth visit in a calendar year
- Cardiac and Pulmonary rehabilitative services
- Developmental Evaluation and Treatment Services
- Respiratory therapy services except for initial evaluation
- MRI, MRA, MRS, MRT when not performed in the emergency room or as part of an approved inpatient confinement

- PET or SPEC scans when not performed in the emergency room or as part of an approved inpatient confinement
- CT, CTA scans when not performed in the emergency room or as part of an approved inpatient confinement
- Transplant services
- Hospice
- Implantable devices including cochlear implants
- Sleep studies, sleep therapies and supplies
- Any Out of Network requests

For a complete list of services requiring prior authorization, please visit www.chatn.org.

RESOURCES TO HELP YOU STAY HEALTHY

The Plan believes in giving You the tools You need to be an educated health care consumer. The Plan has several convenient phone and internet educational and support services you can use by phone and internet, which can help You to:

- take care of Yourself and Your family members
- manage a chronic health condition
- navigate the complexities of the health care system

HEALTH RESOURCES WEBSITE

www.chatn.org provides information anywhere and anytime You have access to the internet. The website opens the door to a wealth of health information and convenient self-service tools.

REGISTERING ON WEBSITE

If You have not already registered as a member go to www.chatn.org. Have Your card handy. The enrollment process is quick and easy.

If You do not know Your logon ID, contact the Plan's Customer Service. The phone number is located on Your ID card.

HEALTH INFORMATION

You can:

- Search for Network Providers through the online Provider directory
- Research a health condition and treatments to get ready for a visit with Your Physician
- Access wellness topics from Health Coaches
- Complete a health risk assessment to learn about areas of Your health that can be improved so You can live longer and feel better.
- Use the treatment cost estimator to estimate the cost of a procedure.

SELF-SERVICE TOOLS

Visit www.chatn.org to:

- make real-time inquiries into the status and history of Your claims
- view eligibility and Plan benefit information, including deductibles
- view and print all of Your Explanation of Benefits (EOBs)
- order a new or replacement ID card

If You do not have access to a computer, You can get the same information by contacting a Customer Service representative at the number on Your ID card.

DISEASE MANAGEMENT PROGRAM

Disease Management (DM) is a program to support You and Your Covered Dependents. In DM, members will work with health coaches to set goals, discuss treatment options and improve Your overall health. Through health coaching, You will also get guidance on maintaining a healthy lifestyle and how to follow treatment and medication Plans. DM is available at no cost to all Members and their Covered Dependents. There are DM programs for:

- Coronary Artery Disease
- Diabetes
- Depression
- Attention Deficit with Hyperactivity Disorder (ADHD)

LIFESTYLE MANAGEMENT

Lifestyle Management is health coaching designed to help You reach their individual health goals. Lifestyle changes are hard and whether You are making a small change or a large one, coaching can make a huge difference in helping You reach Your health goals. Lifestyle Management programs may include:

- Nutrition
- Exercise
- Blood Pressure
- Cholesterol
- Tobacco Cessation
- Weight Management
- Stress Management
- Back Care

WHAT'S COVERED UNDER THE HEALTH PLAN

The Plan covers many Medically Necessary services and supplies, subject to any limits or exclusions below. However, the Plan only covers care provided by healthcare professionals or facilities that are licensed, certified or otherwise qualified under state law to provide healthcare services.

PREVENTIVE CARE SERVICES

The following is a list of services required by the Patient Protection and Affordable Care Act and included in the United States Preventive Services Task Force (USPSTF) A and B Recommendations, as amended from time to time. When you receive these services from a Network Provider, the Plan pays 100% without You paying any Deductible or Coinsurance.

If You do not receive these services from a Network Provider, Deductible and Coinsurance will apply or the claim may be denied.

WELL-CHILD CARE

Well-child care includes:

- Alcohol and Drug Use – annual assessments for adolescents;
- Autism – screening for children at 18 and 24 months;
- Behavioral – annual assessments for children of all ages;
- Blood Pressure – annual screening for children age 0-18;
- Cervical Dysplasia – annual screening for sexually active females;
- Congenital Hypothyroidism – screening for newborns;
- Developmental – screening for children under age 3 and surveillance throughout childhood;
- Dyslipidemia – annual screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention – fluoride supplements prescribed by a Primary Care Physician for preschool children older than 6 months whose primary water source is deficient in fluoride;
- Gonorrhea – prophylactic ocular topical medication for all newborns;
- Hearing – screening for hearing loss in all newborns;
- Hematocrit or Hemoglobin – annual screening for children;
- Hemoglobinopathies – screening for sickle cell disease in newborns;
- Hypothyroidism – screening for congenital hypothyroidism in newborns;
- Immunization – vaccines for children from birth to age 18, recommended ages, frequency and populations will vary with each vaccine;
- Iron – supplements for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia;
- Lead – annual screening for children at risk of exposure;
- Obesity – annual screening and counseling for children age 6 and older;
- Phenylketonuria (PKU) – screening for PKU in newborns;
- Skin Cancer – behavioral counseling for children, adolescents and young adults ages 10-24 who have fair skin about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer;
- Tuberculin – testing for children at higher risk of tuberculosis;
- Vision – screening for all children at least once between the ages 3-5 to detect the presence of amblyopia or its risk factors.

WELL-ADULT CARE

Well-adult care includes:

- Abdominal Aortic Aneurysms – one-time screening for men age 65-75 who have ever smoked;
- Alcohol Misuses – annual screening and counseling in primary care settings;
- Aspirin – use to prevent myocardial infarctions in men age 45-79 and women age 55-79;
- Blood pressure – annual screening for all adults over the age of 18;
- Cholesterol – annual screening for men age 35 and above, for men age 20-35 if they are at increased risk for coronary heart disease, for women age 45 and above, for women age 20-45 if they are at increased risk for coronary artery disease;
- Colorectal cancer – annual screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy for adults age 50-75;
- Depression – annual screening for adolescents age 12-18 for major depressive disorder and adults for depression;
- Type 2 Diabetes – annual screening for adults with sustained high blood pressure;
- Diet – annual counseling for adults at higher risk for diet-related chronic disease;
- Falls prevention – exercise or physical therapy to prevent falls

and vitamin D supplementation in community-dwelling adults age 65 and older who are at increased risk for falls;

- Human Immunodeficiency Virus (HIV) – annual screening for all adolescents and adults at increased risk for HIV infection;
- Immunizations – Vaccines for adults, recommended ages, frequency and populations will vary with each vaccine;
- Obesity – screening for obesity with an offer or referral to intensive, multicomponent behavioral interventions for patients with a body mass index of 30 kg/m^2 or higher;
- Sexually Transmitted Infection (STI) – annual prevention counseling for sexually active adolescents and adults at increased risk for STIs;
- Tobacco Use – annual screening for all adults and cessation interventions for tobacco users;
- Syphilis – annual screening for all adults at increased risk for syphilis infection.

WELL-WOMAN CARE

Well-woman care includes:

- Anemia – screening in asymptomatic pregnant women;
- Bacteriuria – urinary tract or other infection screening for pregnant women at 12-16 weeks gestation or the first prenatal visit, whichever is later;
- Breast Cancer Susceptibility Gene Testing (BRCA) – counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes;
- Mammography – screenings once as a baseline for women at least 35 but less than 40, once every 2 years for women at least 40 but less than 50, once per year for women at least 50, or in accordance with the most recent published guidelines of the American Cancer Society;
- Chemoprevention – counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention;
- Breastfeeding – support and counseling from trained providers during pregnancy and after birth to promote and support breastfeeding and access to breastfeeding supplies for pregnant and nursing women in conjunction with each birth;
- Cervical Cancer – screening in women ages 21-65 with cytology (pap smear) every 3 years or, for women ages 30-65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
- Chlamydia Infection – annual screening for all sexually active non-pregnant women age 24 and younger, older non-pregnant women at increased risk, pregnant women age 24 and younger, and older pregnant women who are at increased risk;
- Contraception – Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed, not including abortifacient drugs;
- Domestic and Interpersonal Violence – annual screening and counseling for all women;
- Folic Acid – supplements for women planning or capable of pregnancy;
- Gestational Diabetes – screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea – annual screening for all women at increased risk for infection;
- Hepatitis B – annual screening for pregnant women at their first prenatal visit;
- Human Immunodeficiency Virus (HIV) – annual screening and counseling for sexually active women;
- Human Papillomavirus (HPV) DNA Test – High-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
- Intimate partner violence screening – screening for women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This applies to women who do not have signs or symptoms of abuse;
- Osteoporosis – screening for osteoporosis in women age 65 and older and in younger women whose fracture risk is equal or greater than that of a 65 year old white woman who has no additional risk factors;
- Rh Incompatibility – screening for all pregnant women during their first prenatal visit and follow-up testing for women at higher risk at 24-28 weeks gestation;
- Tobacco Use – annual screening and interventions for all women and expanded counseling for pregnant tobacco users;
- Syphilis – screening for all pregnant women;
- Well-Woman Visits – annual visits to obtain recommended preventive services.

It is important to note that any qualifying preventive care services that fall outside of the above lists, including all prescriptions will not be payable at 100%; however, will be considered for coverage under the Plan's Deductible, Coinsurance and coverage components.

STANDARD SERVICES COVERED UNDER HEALTH COVERAGE

The Plan covers a wide range of medical expenses, provided they are rendered by an In-Network Provider and are determined to be Medically Necessary or usual to the treatment of an Illness or Injury, as determined by the Plan's medical staff or an independent medical Physician review panel.

When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet your needs, the Plan reserves the right to provide payment for the least expensive Covered Service alternative.

The following is a listing of Covered Expenses payable under the Plan:

AMBULANCE SERVICES

Medically Necessary land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to you. Covered Services include:

- Medically Necessary land or air transportation to or from the scene of an accident or Emergency.

BEHAVIORAL HEALTH

Medically Necessary treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Covered Services include:

- Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders;
- Treatment of medical conditions underlying, or resulting from, behavioral health disorders.

DENTAL SERVICES

- Medically Necessary services performed by a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD) or any Physician licensed to perform dental related oral surgery except as indicated herein. Covered Services include: Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident;
- For dental services not listed above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are covered, only when one of the 5 conditions listed below is met:
    - Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;
    - Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
    - Mental illness or behavioral condition that precludes dental surgery in the office;
    - Use of general anesthesia and the member's medical condition requires that such procedure be performed in a Hospital; or
    - Dental treatment or surgery performed on a member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.
- Oral appliances to treat obstructive sleep apnea, if Medically Necessary.
- Routine dental services for children under age 18.

DIABETES TREATMENT

Medically Necessary diagnosis and treatment of diabetes. In order to be covered, such services must be prescribed and certified by a Physician as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. Covered Services include:

- Blood glucose monitors, including monitors designed for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Insulin;
- Injection aids;
- Syringes;
- Lancets;
- Oral hypoglycemic agents;
- Glucagon emergency kits;
- Injectable incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes;
- Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is covered

only for pumps older than 48 months and if the pump cannot be repaired;
- Podiatric appliances for prevention of complications associated with diabetes.

DIAGNOSTIC SERVICES

Medically Necessary diagnostic radiology services and laboratory tests. Covered Services include:

- Imaging services ordered by a Physician, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, SPEC scans and nuclear cardiac imaging;
- Diagnostic laboratory services ordered by a Physician.

DRUGS

Medically Necessary pharmaceuticals for the treatment of disease or injury. Covered Services include:

- Benefits for the treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician;
- Pharmaceuticals that are dispensed or intended for use while you are confined in a Hospital, skilled nursing facility or other similar facility.

The Plan includes coverage for Prescription Drugs.

You must purchase covered medications from a Network Pharmacy to receive Prescription Drug benefits. If you use a Non-Network Pharmacy, Prescription Drugs will not be covered.

OVER-THE-COUNTER MEDICATIONS

Over-the-counter medications are not a covered benefit, unless they appear on the Plan formulary.

MAINTENANCE DRUGS

If you take a medication on a regular or long-term basis, it may be considered a maintenance medication. You have the option to fill maintenance medications for up to a 90-day supply at either a local retail network pharmacy or at the Plan's approved mail order pharmacy. To find out if your medication is classified as a maintenance drug and eligible for a 90-day supply, please consult the formulary of medications available at www.chatn.org or contact the Customer Service number listed on your ID card.

SPECIALTY MEDICATIONS

Specific "specialty" medications must be filled at the Plan's approved specialty pharmacy Provider to receive benefits. If these "specialty" medications are filled at a non-approved specialty pharmacy provider, they will not be covered. To find out if your medication is classified as a "specialty" medication, please consult the formulary of medications available at www.chatn.org or contact Customer Service at the number listed on your ID card.

DURABLE MEDICAL EQUIPMENT

Medically Necessary medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to you; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Physician for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for your convenience. Covered Services include:

- Rental of Durable Medical Equipment. Maximum allowable rental charge is not to exceed the total maximum allowable charge for purchase. If you rent the same type of equipment from multiple Durable Medical Equipment Providers and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, you will be responsible for amounts in excess of the maximum allowable charge for purchase;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Supplies and accessories necessary for the effective functioning of covered Durable Medical Equipment;
- The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is covered for pumps older than 48 months and only if the pump cannot be repaired.

FAMILY PLANNING AND REPRODUCTIVE SERVICES

Medically Necessary family planning services and those services to diagnose and treat diseases that may adversely affect fertility. Covered Services include:

- Benefits for (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing;
- Sterilization procedures;
- Services or supplies for the evaluation of infertility;
- Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

HABILITATION SERVICES

Medically Necessary health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HOME HEALTH CARE SERVICES

Medically Necessary services and supplies provided in your home by a Provider who is primarily engaged in providing home health care services. Covered Services include:

- Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse;
- Home infusion therapy;
- Rehabilitative therapies such as physical therapy, occupational therapy, etc.;
- Medical social services;
- Dietary guidance.

HOSPICE

Medically Necessary services and supplies for supportive care where life expectancy is 6 months or less. Covered Services include:

- Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

HOSPITAL EMERGENCY CARE SERVICES

Medically Necessary health care services and supplies furnished in a Hospital emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol. Covered Services include:

- Medically Necessary Emergency services, supplies and medications necessary for the diagnosis and stabilization of your Emergency condition;
- Physician services.

INPATIENT HOSPITAL SERVICES

Medically Necessary services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24-hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility. Covered Services include:

- Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room);
- General nursing care;
- Medications;
- Injections;
- Diagnostic services;
- Special care units;
- Attending Physician's services for professional care;
- Maternity and delivery services (including routine nursery care and complications of pregnancy). If the hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits may be covered for the baby and mother as separate members, requiring payment of applicable member copayments and/or Deductibles.

ORGAN TRANSPLANTS

Medically Necessary services and supplies provided to You, when you are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in the Plan's discretion, are not Experimental or Investigational and that are Medically Necessary and Medically Appropriate. Covered Services include:

- Medically Necessary services and supplies at approved locations of service, otherwise covered under this EOC;
- Travel expenses for Your evaluation prior to a covered procedure, and to and from the site of a covered procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for you and a companion. A companion must be your spouse, family member, or your guardian;
    - Travel by private care is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility.
    - Meals and lodging expenses, limited to $150 daily.
    - The aggregate limit for travel expenses is $10,000 per covered procedure.
- Donor organ procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from the donor's body; (3) preservation of the organ; (4) transportation of the organ

to the site of the transplant; and (5) donor follow-up care. Services are covered only to the extent not covered by other health coverage. The search process and securing the organ are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of donor organ procurement is included in the total cost of your organ transplant.

- Use of Centers of Excellence for Transplant Procedures. The use of a Center of Excellence for transplant procedures **is required** to receive full benefits under the Plan. Call the Plan for complete information on transplant benefits and Centers of Excellence.

OUTPATIENT FACILITY SERVICES

Medically Necessary diagnostics, therapies and Surgery occurring in an outpatient facility that includes: (1) outpatient Surgery centers; (2) the outpatient center of a Hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Physician's office. Covered Services include:

- Physician services;
- Outpatient diagnostics (such as x-rays and laboratory services);
- Outpatient treatments (such as medications and injections);
- Outpatient Surgery and supplies;
- Observation stays less than 24 hours.

PHYSICIAN'S OFFICE SERVICES

Medically Necessary services in a Physician's office. Covered Services include:

- Diagnosis and treatment of illness or injury. (Note that allergy skin testing is covered only in the Physician's office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is covered in the Physician's office setting and in a licensed laboratory);
- Injections and medications administered in a Physician's office, except Specialty Drugs. (See Provider Administered Specialty Drugs for information on coverage);
- Second surgical opinions given by a Physician who is not in the same medical group as the Physician who initially recommended the Surgery.

PROSTHETICS/ORTHOTICS

Medically Necessary devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery. Covered Services include:

- The initial purchase of surgically implanted prosthetic or orthotic devices;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Splints and braces that are custom made or molded, and are incidental to a Physician's services or on a Physician's order;
- The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging;
- The initial purchase of artificial limbs or eyes;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Hearing aids for members under age 18, as limited herein.

PROVIDER ADMINISTERED SPECIALTY DRUGS

Medically Necessary Specialty Drugs will be covered under the Prescription benefits for the treatment of disease, administered by a Physician or home health care agency and listed as a Physician-administered drug on the Plan's Specialty Drug list. Covered Services include:

- Provider-administered Specialty Drugs, including administration by a qualified Physician.

RECONSTRUCTIVE SURGERY

Medically Necessary Surgical Procedures intended to restore normal form or function. Covered Services include:

- Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state;
- Reconstructive breast Surgery due to a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

SKILLED NURSING CARE

Medically Necessary Inpatient care provided to Members requiring medical rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a Hospital setting, or custodial or functional care rendered in a nursing home. Covered Services include:

- Room and board in a semi-private room;
- General nursing care;
- Medications;
- Diagnostics;
- Special care units;

- The attending Physician's services for professional care.

TELEPHONIC AND INTERACTIVE ELECTRONIC INTERCHANGES (E-VISITS)

Telephone Visits and e-visits between in network licensed Providers and members with documentation of clinical assessments and recommendations are eligible services.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Medically Necessary services to diagnose and treat Temporomandibular Joint Syndrome or Dysfunction (TMJ or TMD). Covered Services include:

- Diagnosis and management of TMJ or TMD;
- Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon;
- Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) oral appliances to stabilize the jaw joint.

THERAPEUTIC/REHABILITATIVE/ HABILITATIVE SERVICES

Medically Necessary and Appropriate therapeutic, habilitative and rehabilitative services performed in a Physician's office, outpatient facility or home health setting. Covered Services include:

- Outpatient, home health or office therapeutic, habilitative and rehabilitative services that are performed by, or under the direct supervision of a licensed therapist. Must have written authorization of the treating Physician;
- Therapeutic/Rehabilitative /Habilitative Services include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Physician's office, outpatient facility or home health setting. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits. Office visits for care other than actual therapy do not count towards those visit limits.

SUPPLIES

Medically Necessary expendable and disposable supplies for the treatment of disease or injury. Covered Services include:

- Supplies for the treatment of disease or injury used in a Physician's office, outpatient facility or inpatient facility;
- Supplies for treatment of disease or injury that are prescribed by a Physician and cannot be obtained without a Physician's prescription.

VISION

- Medically Necessary diagnosis and treatment of diseases and injuries that impair vision. Covered Services include: Services and supplies for the diagnosis and treatment of diseases and injuries to the eye;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Routine vision services for children under 18.

NOTIFICATION

To understand your costs for a scheduled inpatient admission or select outpatient procedures, you should call the Plan at the number listed on your Plan ID Card. For a complete list of procedures requiring notification, please visit www.chatn.org.

BENEFIT LIMITS AND EXCLUSIONS

Although the Plan covers most necessary medical expenses, there are some expenses that are not covered. This section outlines exclusions and limits of Your medical coverage. This list is not all-inclusive; if You have questions about a particular service or supply; contact the Plan at the telephone number appearing on the identification card.

BENEFIT LIMITS

In addition to the exclusions listed below, refer to the *Schedule of Benefits* section in the Exhibit for any Plan Year limit applicable to certain Covered Expenses. Plan Year limits are met by days/visits/dollar limits paid under all components of the Health Plan option in which You are enrolled. If You need additional information, contact the Plan at the telephone number appearing on the identification card.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan will not pay for or otherwise cover the cost of drugs or treatments considered Experimental and/or Investigational.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

EXCLUSIONS UNDER THE PLAN

No payment will be made under any benefit for expenses incurred in connection with the following, unless specifically stated otherwise in this document.

- Abortions, unless performed in order to save the life of the mother or if the fetus is not viable. Complications from an abortion performed to save the life of the mother are also covered.
- Amounts in excess of any Health Coverage limits.
- Any care connected with military service conditions for which an employee is legally entitled to service and for which facilities are reasonably accessible. This includes any charges incurred while on active duty with the armed services of any country or international organization.
- Adoption or surrogate expenses.
- Ambulance Services:
  - Transportation for Your convenience;
  - Transportation that is not essential to reduce the probability of harm to You;
  - Services when You are not transported to a Hospital.
- Any care not recommended and approved by a licensed Physician.
- Any charges of a Physician or health professional for services he or she provides to herself or himself or to any close relative. Close relative means spouse, domestic partner, brother, sister, parent, grandparent or child and the spouse's or domestic partner's brothers, sisters, parents, grandparent or child.
- Any charges for treatment, services or supplies that are not Medically Necessary or usual for the treatment of an Illness or Injury as determined by the Plan's medical staff or an independent medical Physician review panel. This does not apply to qualifying preventive care services or other health care services specifically covered under the Plan that are not required to preserve Your health.
- Any dental care, treatment, implants, surgery, or supplies, except for the following:
  - repair started within 3 months of accidental injuries and completed within 12 months to

sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan; or

- o inpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement (inpatient or outpatient) is deemed to be an underlying serious and hazardous medical condition.

- Any diagnostic admission to a facility if the test can be performed in a less restrictive or dangerous environment on an outpatient basis.
- Any Illness or Injury for which benefits or payments are received (or could be received if claims were made) under any workers' compensation law, employer's liability law or similar act.
- Any Illness or Injury for which any benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for Covered Services under the Plan.
- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community supported in the peer reviewed medical literature.
- Arch supports, foot orthotics costing in excess of $500 or not prescribed by a medical doctor, and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition.
- Augmentative communications devices.
- Autopsies.
- Balloon sinuplasty for treatment of chronic sinusitis.
- Behavioral health conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- Blepharoplasty, rhinoplasty, abdominoplasty, browplasty, or other cosmetic procedures.
- Charges for duplicating and obtaining medical records.
- Charges for or related to fetal tissue transplants.
- Charges related to organ transplants except as specified in the section entitled, *Organ Transplants*.
- Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is covered under this Plan.
- Charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Note: Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are eligible.
- Charges for reconstructive surgery relating to aesthetic appearance and related services, except for the following:
  - o reconstructive surgery and related charges following a covered mastectomy;
  - o surgery to repair a defect caused by an accidental Injury resulting in a functional impairment;
  - o reconstructive surgery related to an Injury, Sickness, or other disease of that part of the body;
  - o reconstructive surgery following surgery that was needed due to an Injury, Sickness, or other disease of that part of the body;
  - o cosmetic or reconstructive surgery or treatment to repair a Dependent child's congenital malformation or developmental defect.
- Charges for telephone calls with the office of a health professional for the failure to keep a scheduled visit, mailing, shipping and handling expenses, completing any form, for medical information, or other administrative services.
- Charges for the treatment of compulsive gambling.
- Charges that exceed the allowed amounts and/or the Usual and Customary Charge.
- Charges in excess of the Maximum Allowable Charge for Covered Services.
- Charges for Gastric bypass, roux-en-Y, duodenal switch, sleeve gastrectomy, laparoscopic lap band. Additionally, any new or related procedures done for the purpose of weight reduction, elimination of obesity or the co-morbidities of obesity are also excluded.
- Charges for a drug, device, diagnostic or screening procedure, or a medical treatment or procedure of an Experimental or Investigative nature or an Unproven Service as determined by the Plan. This does **not** include drugs that: a)

have been granted investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease as determined by the Plan. In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information , or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan.

- Charges for handling fees.
- Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
- Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning.
- Cosmetic services, except as appropriate per medical policy. This exclusion applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to, Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins; (12) piercing ears or other body parts, (13) rhytidectomy or rhytidoplasty (surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculectomy/abdominoplasty; (16) thighplasty; (17) brachioplasty.
- Court ordered examinations and treatment, unless Medically Necessary.
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
- Custodial care or domiciliary care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional.
- Dental Services:
  - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;
  - Treatment for correction of underbite, overbite, and misalignment of the teeth including, but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth;
  - Extraction of impacted teeth, including wisdom teeth.
- Diabetes Treatment:

- Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

- Diagnostic Services:
  - Diagnostic services that are not Medically Necessary;
  - Diagnostic services not ordered by a licensed Practitioner.

- Durable Medical Equipment:
  - Charges exceeding the total cost of the maximum allowable charge to purchase the equipment;
  - Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
  - Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
  - Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
  - Items that require or are Dependent on alteration of home, workplace or transportation vehicle;
  - Motorized scooters, exercise equipment, hot tubs, pools and saunas;
  - "Deluxe" or "enhanced" equipment. Basic equipment that will provide the medically necessary intervention will determine the benefit;
  - Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs and seat lifts of any kind;
  - Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved as Medically Necessary;
  - Portable ramp for a wheelchair.

- Enteral feeding formulas, except for the following:
  - prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies; or
  - oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally.

- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling or while on short or long-term international assignment.

- Expenses used to satisfy Plan Deductibles and/or coinsurance.

- Expenses eligible for consideration under any other Plan, including Medicare.

- Expenses not specifically listed as Covered Expenses under this Plan.

- Expenses incurred as a result of Your being drunk or under the influence of any controlled substance unless taken in accordance with the advice of a Physician for medically necessary care.

- Family Planning and Reproductive Services:
  - Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology; (6) fertility injections; (7) fertility drugs; (8) services for follow-up care related to infertility treatments;
  - Services or supplies for the reversals of sterilizations;
  - Sperm preservation;
  - Induced abortion unless: (1) the health care Provider certifies in writing that the pregnancy would endanger the life of the mother.

- Full body scans, EBCT (heart scans).

- Gene therapy as a treatment for inherited or acquired disorders.

- Homeopathic visits.

- Health services needed from attempting to commit or committing a felony, or engaging in an illegal occupation.

- Health services performed before the effective date or after the termination of coverage under this Plan.

- Hearing aids for members age 18 or older.

- Home construction needed for the installation of special, Medically Necessary equipment.

- Home Health Care Services:
  - Items such as non-treatment services;
  - Routine transportation;
  - Homemaker or housekeeping services;
  - Behavioral counseling;
  - Supportive environmental equipment;
  - Maintenance care or custodial care;
  - Social casework;

- Meal delivery;
- Personal hygiene; and
- Convenience items.

- Hospice Care:
  - Unapproved Inpatient services;
  - Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.
- Hospital Emergency Care Services:
  - Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
  - Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless prior authorization is obtained from the Plan within 24 hours or the next working day.
- Hypnosis or regressive hypnotic techniques.
- Inpatient Hospital Services:
  - Inpatient stays primarily for therapy (such as physical or occupational therapy) that can be safely and effectively provided in less restrictive and risky environments;
  - Services that could be provided in a less restrictive environment at less cost to Member and health Plan
  - Private room when not authorized by the Plan and room and board charges are in excess of semi-private room;
  - Blood or plasma that is provided at no charge to the patient.
- Illness or Injury resulting from war, that occurred before Your coverage began under this Plan and that is covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
- Lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition, except when determined to be Medically Necessary following cataract surgery.
- Liposuction or Lipotherme.
- Marriage counseling.
- Maternity expenses for Dependents unless life threatening complications.
- Medical services or products purchased outside of the U.S., unless in an unexpected, emergency situation.
- Organ Transplants:
  - Services or supplies not specified as Covered Services;
  - Any attempted covered procedure that was not preformed, except where such failure is beyond Your control;
  - Non-Covered Services;
  - Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;
  - Any non-human, artificial or mechanical organ;
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
  - Any services which require prior authorization where such authorization is not received;
  - Removal of an organ from a Member for purposes of transplantation into another person, except as allowed by the Plan;
  - Harvest, procurement and storage of stem cells, whether obtained from peripheral blood, cord blood or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis;
  - Other non-organ transplants (e.g. cornea).
- Prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Prosthetics or Orthotics:
  - Hearing aids for members age 18 or older;

- Prosthetics primarily for cosmetic purposes, including, but not limited to: wigs, or other hair prosthesis or transplants;
- Items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology;
- The replacements of contacts after the initial pair have been provided following cataract surgery;
- Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as part of a leg brace.

- Non-prescription drugs or medicines, except for those which appear on the formulary as a covered benefit and are prescribed by a licensed Practitioner.
- Non-emergency admissions greater than 24 hours in advance of procedure unless specified by Your Physician.
- Non-medical counseling or training services.
- Treatment by artificial means for the purpose of causing a pregnancy, such as but not limited to: prescription drugs, donor ova and sperm and artificial or intrauterine insemination procedures, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer.
- Outpatient Facility Services:
  - Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit;
  - Services that could be provided in a less intensive setting.
- Personal comfort items while Hospitalized such as telephone or television; Hospital room and board expenses that exceed the semi-private room rate unless a private room is approved as Medically Necessary.
- Physician Office Services:
  - Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings;
  - Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) calluses; (4) toenails; (5) fallen arches; and (6) weak feet or chronic foot strain;
  - Rehabilitative therapies in excess of the limits of the Therapeutic/Rehabilitative benefit;
  - Dental procedures, except as otherwise indicated in this EOC.
- Physician charges for injections that can be self-administered.
- Phototherapy devices for Seasonal Affective Disorder.
- Private duty nursing services.
- Provider Administered Specialty Drugs:
  - Self-administered Special Drugs;
  - FDA-approved drugs used for purposes other than those approved by the FDA, except as provided herein.
- Reconstructive Surgery:
  - Services, supplies or prosthetics primarily to improve appearance;
  - Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service;
  - Surgeries and related services to change gender (transsexual surgery).
- Recreational or educational therapy or forms of non-medical self care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing.
- Reversal of sterilization.
- Routine physical exams and immunizations for employment, travel or insurance purposes.
- Safety items, or items to affect performance primarily in sports-related activities.
- Sales tax.
- Self treatment or training.
- Services of the clergy.
- Services that are prohibited by law or regulations.
- Services or confinements ordered by a court or law enforcement officers that are determined not Medically Necessary (an initial court-ordered exam for a Dependent child under age 18 years is considered Medically Necessary).
- Services rendered by anyone other than a covered healthcare Provider. Services provided mainly for rest cures, the ease of a household, or sanitarium care.
- Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer

equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician.

- Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group.
- Services or supplies for Maintenance Care.
- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
- Services or supplies that are determined to be not Medically Necessary.
- Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
- Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary.
- Services, supplies, chemotherapy, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered.
- Services related to mental retardation.
- Services that are free.
- Skilled Nursing/Rehabilitative Facility Services:
  - Custodial, domiciliary or private duty nursing services;
  - Skilled nursing services not received in a Medicare certified skilled nursing facility;
  - Services for cognitive rehabilitation.
- Sleep disorders.
- Staff consultations required by hospital or other facility rules.
- Supplies that can be obtained without a prescription (except for diabetic supplies).
- Temporomandibular Joint Dysfunction (TMJ) – The following services sometimes associated with TMJ are not covered under the Plan's medical benefits:
  - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;
  - Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.
- Therapeutic/Rehabilitative/ Habilitative Services:
  - Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
  - Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) cognitive rehabilitation; (5) vision exercise therapy; and (6) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit;
  - Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver;
  - Behavioral therapy, play therapy, communication therapy, and therapy for self correction language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;

- Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

- Travel and/or lodging expenses of a Physician or a patient, except as specified in the Organ Transplant section.
- Treatment for benign gynecomastia.
- Treatment for hyperhidrosis.
- Treatment while confined in a state, federal or Veterans Administration Hospital for which charges are not imposed.
- Transportation other than local ambulance service for a medical emergency to the nearest Hospital that can provide care. Air ambulance covered if only reasonable means of transport available.
- Vagus nerve stimulation for the treatment of depression.
- Vision:
  - Routine vision services for adults over age 19, including services, surgeries and supplies to detect or correct refractive errors of the eyes;
  - Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
  - Eye exercises and/or therapy;
  - Visual training.
- Vocational and educational training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs.

DESCRIPTION OF IN-NETWORK AND OUT-OF-NETWORK UNDER THE HEALTH PLAN

This section includes information about how In-Network and Out-of-Network Benefits work and how emergency health services are covered.

IN-NETWORK BENEFITS

In-Network benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are payable for Covered Expenses which are:

- Provided by a Network Physician or other Network Provider, or
- Considered to be an Out-of-Network Benefit exception.

Payment for In-Network Benefits are based on the Network Provider's negotiated rate as established by the Provider's Network. Network Providers have agreed not to Balance Bill you for the difference between their charges and what the Plan pays.

PROVIDER NETWORK

The Plan arranges for health care providers to participate in a Network. Network Providers are not our employees or employees of the Plan. It is Your responsibility to select Your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services, You should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when You are referred by another Network Provider. You can verify the provider's status by calling Your Plan at the number on Your ID card.

It is possible that You might not be able to obtain services from a particular Network Provider. The network of providers is subject to change. Or, You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Services. Some Network Providers agree to provide only certain Covered Services, but not all Covered Services. Some Network Providers choose to be a Network Provider for only some products. You may contact the Plan at the number on Your ID card for assistance in choosing a provider or with questions about a particular provider's Network status.

OTHER PROVIDERS

If You have a medical condition that the Plan believes needs special services, we may choose a provider for you.. If You require certain complex Covered Services for which expertise is limited, the Plan may direct You to an Out-of-Network Provider.

In both cases, Benefits will only be paid if the chosen provider provides or arranges for Your Covered Services. provider

OUT-OF-NETWORK BENEFITS

Out-of-Network Benefits are not covered by the Plan except for Emergency services as provided herein.

WHAT IF I'M TRAVELING AND NEED MEDICAL CARE?

If you are traveling outside your network and you need medical care, you should contact Customer Service at the telephone number appearing on the identification card or log onto www.chatn.org for assistance is locating the nearest Network Provider. If you need Emergency Care, however, go ahead and get the care you need.

EMERGENCY CARE

The Plan provides Benefits for Emergency Care when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

In-Network Benefits are paid for Emergency Care, even if the services are provided by an Out-of-Network Provider.

CONFINEMENT IN AN OUT-OF-NETWORK HOSPITAL FOLLOWING AN EMERGENCY

If You are confined in an Out-of-Network Hospital after You receive Emergency Health Services, the **Plan must be notified within two (2) business days or on the same day of admission if reasonably possible.** The Plan may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Out-of-Network Hospital after the date the Plan decides a transfer is medically appropriate, Out-of-Network Benefits may be available if the

continued stay is determined to be a Covered Service.

OTHER EXCEPTIONS

If, while an Inpatient or receiving Outpatient services, You have an x-ray, receive laboratory services, or anesthesia services from an Out-of-Network Provider while You are in an In-Network facility, we will cover the service at the In-Network benefit level.

CLAIMS PROCEDURES UNDER THE HEALTH PLAN

Claims are processed according to the benefits of the Plan You selected. Please review Your Schedule of Benefits for further information on Your Plan. You can also visit our website at www.chatn.org or call Customer Service for further details on Your Plan selection.

HOW CLAIMS ARE PROCESSED

When You receive care from Your health care Provider, You will present Your ID card. Your Provider should submit a claim for payment directly to the Plan Your Provider does not file a claim on Your behalf, follow the procedures below, under *Submitting a Claim*.

SUBMITTING A CLAIM

You may be responsible for submitting a claim directly to the Plan. Check with your Provider to see if You must file the claim. Any claim You need to submit should be mailed to the Plan. You may download claim forms from our web site through our Member portal at www.chatn.org or by calling the Customer Service number on Your ID card if You are unable to print a claim form.

For information on how to file a claim for pharmacy benefits, contact Customer Service.

You must submit Your claims to the Plan within 15 months of the date of service. Benefits for Your service can be denied or reduced, at the Plan's discretion, if not received timely.

REQUIRED INFORMATION

Please be prepared to provide the following information when submitting Your claim form:

- Your name, date of birth and address;
- The patient's name, if different from Yours, the date of birth and family relationship to You;
- The Member number stated on Your ID card; and
- An itemized bill from Your Provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure Code(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - The Provider's Name, Address and Tax Identification Number.

Note: If you paid the provider directly and are submitting Your claim for reimbursement, You must also include a receipt showing proof of payment.

Submit Your claims to the address appearing on Your ID card.

PROVIDING AUTHORIZATION

In Your application, You have agreed that Your Provider may provide the Plan with the needed information about the care they provide to You. The Plan keeps all such information strictly confidential. If a Provider requires specific authorization to release records, You agree to provide this authorization. Your failure to provide authorization or any requested information may result in denial of Your claim.

CLAIMS PAYMENTS

Payments will be made directly to the Providers who have submitted a claim to the Plan on Your behalf.

Payments for manually submitted claims or Out-of-Network claims will be made to You unless either of the following is true:

- The Provider notifies the Plan that it has Your signature on file, assigning benefits directly to that Provider.; or
- You make a written request for the Out-of-Network Provider to be paid directly at the time You submit Your claim.

When Your claims are processed for payment, You will receive a notice of the action taken by the Plan in the form of an Explanation of Benefits or EOB. The EOB provides the details of how the claim was processed. For example; it will show how much the Plan paid Your Provider, the procedures performed, the date the service was performed, and the amount of money You may owe the Provider, if any.

The EOB will also show if the Plan did not process or pay Your claim. In some cases, additional information may be needed or is requested to complete claim payment. Or, the claim may be denied payment by the Plan. The EOB will state the specific reason or reasons for the denial and will refer to specific Plan provisions on which the denial is based. It will also contain a description of any information necessary for the claim to be processed and an explanation of why such information is necessary. The EOB will also tell You how to file a formal Appeal and the time limits for filing an Appeal. It will also include Your right to bring a civil

action following an adverse determination upon Appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to Your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

QUESTIONS AND APPEALS

This section provides You with the information to help You if:

- You have a question or concern about the Covered Service or Your Benefits.
- You are notified that a claim has been denied because the service or supply is excluded under the Plan and You wish to Appeal such determination.

Nothing prevents You from filing a complaint with the Tennessee Department of Commerce and Insurance. However, such complaints are separate from, and in addition to, the Appeals processes in this EOC.

To resolve a question or file an Appeal, just follow these steps:

WHAT TO DO FIRST

If Your question or concern is about a benefit determination, please contact Customer Service before requesting a formal Appeal. We have staff that is dedicated to resolving customer concerns. If we are unable to resolve the issue, please review and follow the instructions listed in the next section, *How to File an Appeal*.

Customer Service is available to take Your call during regular business hours, Monday through Friday from 8am to 6pm.

HOW TO FILE AN APPEAL

If You disagree with a benefit determination after following the above steps, You may contact Customer Service in writing or over the phone to formally request an Appeal. Your request should include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason You believe the claim should be paid; and
- Any documentation or other written information to support Your request for claim payment.

Your first Appeal request must be submitted to the Plan within 180 days after You receive notice of the benefit denial.

APPEAL PROCESS

A qualified individual who was not involved in the decision being Appealed will be appointed to decide the Appeal. If Your Appeal is related to clinical matters, the review will be done with a health care professional with expertise in the field who was not involved in the prior determination. The Plan consults medical experts as part of the Appeal resolution process. As part of Your application, You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge, You have the right to reasonable access to and copies of, all documents, records, and other information relevant to Your claim for benefits.

APPEALS DETERMINATIONS

You will be provided written or electronic notification of the decision on Your Appeal. You have two levels of Appeals.

- After the first level Appeal is conducted, You will be notified of the decision within a reasonable time given Your medical condition, but not later than 30 days from receipt of Your request. Within 5 days of receipt of Your request for the first level Appeal, You will be notified of Your right to submit written documents, records and other materials relating Your Appeal. You will also have access to copies of all documents, records and other information, free of charge, which are relevant to Your Appeal.

  A review panel of qualified individuals (the majority of whom were not involved in the first level Appeals decision) will conduct the second level Appeal. They will have the appropriate expertise or have access to the appropriate expertise regarding the subject of the second level Appeal under review.
- Within 5 days of Your request for a second level Appeal, You will be notified of Your right to:
  - Request, within a reasonable amount of time, the opportunity to appear in person before a review panel of designated representatives;
  - Receive, upon request, copies of all documents, records, and other information that is not confidential or privileged with regard to Your request for benefits;
  - Present Your case to the review panel;
  - Submit written comments, documents and records for the review panel to consider;

- If applicable, to ask questions of any representatives on the review panel; and
- Be assisted or represented by an individual of Your choice, at Your own expense.

The Plan Administrator will notify You of the decision on Your second level Appeal within 30 days from the receipt of Your request for a review of the first level Appeal decision.

- For urgent procedures, see *Urgent Appeals that Require Immediate Action* below.

If Your Appeal is denied, You will receive a notice explaining: the reason for the denial; specific references to the part of the Plan on which the denial is based; a statement that You are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; a statement regarding any voluntary Appeal procedures offered by the Plan and Your right to bring a civil action after an Adverse Determination on Appeal; information about the internal rule, guideline or protocol that was relied on, if applicable; and information on the scientific or clinical judgment for the determination if the adverse decision is based on Medical Necessity or experimental treatment.

URGENT APPEALS THAT REQUIRE IMMEDIATE ACTION

Your Appeal may require immediate action if it involves an adverse decision about admission, availability of care, continued stay, or healthcare services when You have received Emergency services but have not yet been discharged. In these urgent situations:

- The Appeal does not need to be submitted in writing. You or Your Physician may request an expedited internal Appeal orally or electronically.
- You will be provided with all documents and information being considered in the expedited Appeal by phone, email, fax, or other reasonable means.
- The Plan will provide You with a determination as quickly as Your condition requires, but not more than 72 hours following Plan receipt of Your urgent Appeal request.
- You can pursue an Expedited External Review while simultaneously pursuing an Expedited (Urgent) Internal Appeal.

STANDARD EXTERNAL REVIEW

You may request a standard external review if:

- You have exhausted the first level of the internal review process documented above under *Appeal Determinations*; or
- The Plan has not provided You with a determination on Your internal Appeal within the applicable time frame.

The request for external review must be received within 6 months of the final internal Adverse Determination.

External review is available if the decision to deny benefits is based on:

- Lack of Medical Necessity
- Failure to meet requirements for appropriateness, setting, level of care, or effectiveness; or
- The exclusion for Experimental, investigational or Unproven services or treatment and Your condition is life threatening or seriously disabling; or
- A rescission of coverage

The Plan will notify You within 3 business days whether or not Your request is eligible for external review. The Plan will also tell You on how to submit additional documentation for Your Appeal.

If Your Appeal is eligible for external review, the Plan will send Your request to an Independent Review Organization (IRO) at no cost to You. A decision will be made on Your external review within 45 days from the date of Your request.

The IRO's decision will be binding and no subsequent review will be available.

EXPEDITED EXTERNAL REVIEW

You may request an expedited external review if the denial:

- Involves a medical condition where the time frame for a standard external review would seriously jeopardize Your life, health or ability to regain maximum function; or
- Was based upon a determination concerning an admission, availability of care, continued stay, or health care service for which You received emergency care and have not been discharged from a Facility.

If Your Appeal is not eligible for an expedited external review, the Plan will notify You in writing.

If Your Appeal is eligible for an expedited external review, the Plan will immediately send Your request to an IRO at no cost to You.

The IRO will make a decision as quickly as Your medical condition or circumstances require, but no more than 72 hours from the time of Your request.

The decision made by the IRO will be binding and no subsequent review will be available.

EXAMINATION AND AUTOPSY

The Plan, at its own expense, may examine the person for whom a claim is made as often as reasonably necessary while a claim is pending. If the Member is deceased, the Plan may have an autopsy performed during the contestability period unless prohibited by law.

COORDINATION OF BENEFITS AND SUBROGATION

If You have health care coverage through another employer, this section is for You. For example, You may be covered as a Dependent under Your spouse's medical Plan. This "coordination of benefits" provision prevents duplicating benefit payments when You or Your Dependent(s) also have coverage through another group plan. Coordination of benefits also determines which plan pays first.

HOW COORDINATION OF BENEFITS WORKS

Covered Expenses not reimbursed by the primary Plan (see below) will coordinate with Your Plan for payment.

Here's how coordination of benefits works: The first step is to determine which plan is primary and which plan is secondary. The primary plan always pays benefits first. When the plan is secondary, benefits are coordinated so that the total benefits from all the plans are no more than the maximum allowed by the Plan.

AN EXAMPLE

Assume your spouse is covered under his or her own employer's plan and as your Dependent under the Plan, and incurs a $100 expense for an office visit.

Let's also assume the Plan considers the allowable expense for the office visit is the full $100.

If your spouse's Plan covers the visit at 80% ($80), the Plan will pay $20 ($100 - $80).

In this example you would be reimbursed a total of $100 ($80 + $20).

ORDER OF COVERAGE—EMPLOYEE AND SPOUSE

- If one of the Plans does not have a coordination of benefits provision, that Plan will pay first.
- If You (or Your spouse) are covered as an employee, member or subscriber by one Plan and as a Dependent by another, the Plan that covers the person as employee, member or subscriber will pay benefits first. If You or Your spouse are also covered by Medicare and are not working:
  - the Plan that covers a person as a Dependent of an employee is primary,
  - Medicare is secondary, and
  - the Plan that covers a person as an employee, member or subscriber pays third.
- If You or Your spouse is covered as an employee and also as a retired or laid off employee (one of them through another employer) the Plan that covers the person as an employee (or a Dependent of an employee) is primary.

ORDER OF COVERAGE—DEPENDENT CHILDREN

For a Covered Dependent child whose parents are not divorced or separated and who is covered as a Dependent under both parents' Plans:

- The Plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered child. For example, if the father's birthday is in March and the mother's birthday is in September, the father's Plan is primary for the child. This is called the "birthday rule."
- If the parents have the same birthday, the Plan that has covered a parent longer will pay benefits first for the child. For example, if the father has had coverage under his Plan for five years and the mother has had coverage under her Plan for seven years, the mother's Plan is primary for the child.
- If the other Plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the Plans don't agree on order, the rules of the other Plan will determine which Plan pays first.

If two or more medical Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined as follows:

If under a court decree the parents have joint custody but the decree doesn't state who is responsible for the child's health care expenses, benefits will be coordinated the same as for the children of married parents.

- The medical Plan of the parent who has a court decree of financial responsibility will be primary.
- If no court decree exists, and
  - the parent with custody has not remarried; the medical Plan of the custodial parent will be primary.
  - the parent with custody has remarried:
    - the Plan of the custodial parent will be primary,
    - the Plan of the stepparent will be secondary, and
    - the Plan of the non-custodial parent will be third.

COORDINATION WITH MEDICARE

If You keep working for Your current employer and You or a Covered Dependent becomes eligible for Medicare, the Plan will remain Your primary Plan and Medicare will be secondary.

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If You are eligible for or enrolled in Medicare, please read the following information carefully. If You are eligible for Medicare on a primary basis (Medicare pays before benefits under the Plan), You should enroll for and maintain coverage under both Medicare Part A and Part B. If You don't enroll and maintain that coverage, and if the Plan is the secondary payer, the Plan will pay benefits under the Plan as if You were covered under both Medicare Part A and Part B. As a result You will be responsible for the costs that Medicare would have paid and You will incur a larger out-of-pocket cost.

OTHER COORDINATION RULES

If none of the above rules determines the order of benefits, the benefits of the Plan that has covered an employee, member or subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of the new Plan does not include: a change in amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another.

The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under the Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Some Plans declare their coverage "in excess" to all other Plans, "always secondary," or otherwise not governed by COB rules. These Plans are "non-complying Plans." This Plan coordinates with non-complying Plans as follows: if this Plan is the primary Plan, it will provide its benefits on a primary basis; if this Plan is the secondary Plan, it will provide benefits first, but the amount of benefits and liability of this Plan will be limited to the benefits of a secondary Plan. If the non-complying Plan does not provide information needed to determine this Plan's benefits within a reasonable time after it's requested, this Plan will assume that the benefits of the non-complying Plan are the same as the benefits of this Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan. If the non-complying Plan reduces its benefits so that the employee, member or subscriber receives less in benefits than he or she would have received had the complying Plan paid, or provided its benefits as the secondary Plan, and the non-complying Plan paid or provided its benefits as the primary Plan; and governing state law allows the right of subrogation, then the complying Plan shall advance to You, or on Your behalf, an amount equal to such difference. However, in no event shall the complying Plan advance more than the complying Plan would have paid, had it been the primary Plan, less any amount it previously paid. In consideration of such advance, the complying Plan shall be subrogated to all Your rights against the non-complying Plan. Such advance by the complying Plan shall also be without prejudice it may have against the non-complying Plan in the absence of such subrogation.

SUBROGATION AND THIRD PARTY RECOVERY

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment

made by this Plan for health care benefits that is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

RIGHT OF REIMBURSEMENT AND RECOVERY

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical benefits and expenses which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

The Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies specifically designated as medical expenses and that: (1) is paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of the Plan pays medical benefits and expenses and the Plan is the primary issuer. ("Subrogated Amount").. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pay and Pursue."** The Plan has elected the "pay and pursue" option in connection with the subrogation, reimbursement and equitable lien rights for claims involving Covered Services. Pursuant to the election of "pay and pursue," benefit payments will be made prior to applying the subrogation, reimbursement and equitable lien rights under the Plan.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any medical benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:
   a. Any no-fault insurance;
   b. Medical benefits coverage under any automobile liability Plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
   c. Under-insured and uninsured motorist coverage;
   d. Any automobile medical payments and personal injury protection benefits;
   e. Any third party's liability insurance
   f. Any premises/guest medical payments coverage;
   g. Any medical malpractice recovery;
   h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of

employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.

i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

4. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.
5. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.
6. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

CONTINUATION OF COVERAGE

COBRA CONTINUATION COVERAGE

This section generally explains COBRA Coverage, when it may become available to You or Your family, and what You need to do to protect the right to receive it.

COBRA Coverage is only available as required by law. Contact the Plan to find out if COBRA is available to You.

OVERVIEW

You and Your Covered Dependents have the option to purchase temporary continuation coverage in certain instances when coverage would otherwise end. This is called COBRA coverage. The right to COBRA Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA coverage for the Plan is administered by:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below and in the table to the right. After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay for COBRA Coverage. If You elect COBRA Coverage, the coverage will be identical to the coverage provided under the Plan to similarly situated employees or their family members at the time coverage is being provided to You.

QUALIFYING EVENTS FOR EMPLOYEES, SPOUSES AND DEPENDENT CHILDREN

If You are an employee, You will become a qualified beneficiary and have a right to choose COBRA Coverage if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary and have a right to choose COBRA Coverage if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both) and loses coverage under the Plan due to the Medicare entitlement; or
- You and Your spouse become divorced or legally separated.

Your Dependent children will become qualified beneficiaries and have a right to choose COBRA Coverage if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent (employee) dies;
- The parent (employee)'s hours of employment are reduced;
- The parent (employee)'s employment ends for any reason other than his or her gross misconduct;

	Maximum COBRA Coverage Period		
Qualifying Event	Employee	Spouse	Dependent Child
Termination of employment (other than for gross misconduct)	18 months	18 months	18 months
Reduction in hours (below hours necessary to meet eligibility requirements)	18 months*	18 months*	18 months*
Employee enrolls in Medicare (as second qualifying event)	N/A	36 months	36 months
Divorce or legal separation	N/A	36 months	36 months
Death of employee	N/A	36 months	36 months
Child ceases to be a dependent child	N/A	N/A	36 months

* 24 months if the reduction in hours results from taking military leave.

- The parent (employee) becomes entitled to Medicare benefits (Part A, Part B, or both) and loses coverage under the Plan due to Medicare entitlement;
- The parents divorce or legally separate;
- The child stops being eligible for coverage under the Plan as a Dependent Child.

In general, a domestic partner (and eligible children of a domestic partner) who lose coverage under the Health Plan are not eligible for COBRA coverage. However, if You lose coverage due to Your termination of employment or reduction in hours and You elect COBRA coverage for Yourself, Your domestic partner (and eligible children of Your domestic partner) will be permitted to elect continued coverage that is similar to COBRA coverage. Contact Customer Service for details.

THE PLAN'S NOTIFICATION REQUIREMENTS

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. When one of the qualifying events occurs, the Plan will notify You of Your rights to choose COBRA Coverage:

- When the qualifying event is the end of employment or reduction of hours of employment;
- When the qualifying event is the death of the employee; or
- When the qualifying event is Medicare (Part A, Part B, or both) entitlement resulting in loss of coverage.

Note: Notices are sent to You at Your last address on file with the Plan Administrator.

YOUR NOTIFICATION REQUIREMENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan. The Plan requires written notification within sixty (60) days after the qualifying event occurs. You must send this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

Your failure to provide notice as required within 60 days will result in a denial of Your request for COBRA Coverage and Your group health coverage will end. Not choosing COBRA Coverage may cause a break in Your group health coverage, and any such break of more than sixty-three (63) days may cause loss of coverage portability.

HOW TO ELECT COBRA CONTINUATION

Once the Plan receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Coverage. Covered employees may elect COBRA Coverage on behalf of their children. Your election notice must be sent within sixty (60) days following the date coverage under the Plan ends or the date You receive notice of Your rights to COBRA Coverage, whichever date is later.

It is important to note that Your failure to make a COBRA election within the time periods required under COBRA will result in a denial of Your request for COBRA Coverage.

If You or Your Covered Dependent chooses COBRA Coverage, You must advise the Plan of Your choice in writing. The Plan may be contacted at:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WHAT ARE YOUR COBRA CONTINUATION PERIODS?

COBRA Coverage is a temporary continuation of coverage.

COBRA coverage can last for up to 36 months when Plan coverage is lost due to:

- the death of the employee,
- the covered employee's divorce or legal separation, or
- a Dependent child's losing eligibility as a Dependent child.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the Covered Person becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours.

COBRA coverage generally can last for only up to a total of eighteen (18) months when Plan coverage is lost due to:

- the end of employment ,or
- reduction of the employee's hours of employment.

EXTENSION OF 18-MONTH CONTINUATION COVERAGE

There are two ways in which this 18-month period of COBRA Coverage can be extended: (1) if a qualified beneficiary is disabled; or (2) a secondary qualifying event occurs.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan becomes a qualified beneficiary is determined by the Social Security Administration to be disabled and You make notification in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA Coverage, for a total maximum of twenty-nine (29) months. The disability must start some time before the 60th day of COBRA Coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual must submit proof of the determination of disability by the Social Security Administration within the initial eighteen (18) month COBRA Coverage period and within sixty (60) days after the latest of (i) the date of the Social Security Administration's disability determination, (ii) the date on which the qualifying event occurs, or (iii) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the qualifying event.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that the person make notification within thirty (30) days of such determination. The notices with regard to disability should specify the name of the Plan, the name of the employee covered by the Plan and the disability determination of which You are giving notice. You must provide this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

If Your family has another qualifying event while receiving 18 months of COBRA Coverage, the qualified beneficiaries in Your family can get up to eighteen (18) additional months of COBRA Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and Dependent children receiving continuation coverage if:

- The employee or former employee dies;
- The employee or former employee and spouse get divorced or legally separated; or
- If the Dependent child stops being eligible under the Plan as a Dependent child.

This extension will be made available only if the individual is a qualifying beneficiary and the event would have caused the spouse or Dependent to lose coverage under the Plan had the first qualifying event not occurred.

The Covered Employee's entitlement to Medicare benefits may also be a second qualifying event that will allow a qualified beneficiary in the covered employee's family to receive up to an additional eighteen (18) months of continuation coverage. This extension is only available if the Medicare entitlement would have resulted in loss of coverage under the Plan had the first qualifying event not occurred. Medicare entitlement normally does not result in a loss of coverage under the Plan; therefore, a second qualifying event extension due to Medicare entitlement will only be available under limited circumstances.

If the subsequent qualifying event is Your divorce or legal separation, Your child's loss of Dependent status or Your entitlement to Medicare, You or Your Dependent must make notification in writing of that event within sixty (60) days of the qualifying event. The notice should specify the name of the Plan, the name of the employee covered by the Plan and the qualifying event of which You are giving notice. You must provide this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

PAYMENT FOR COBRA CONTINUATION COVERAGE

Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay the entire cost for COBRA Coverage, plus an administration fee of up to two percent (2%). The initial payment must be made within forty-five (45) days after the date You notify the Plan that You have chosen to continue coverage. The initial payment is the amount needed to pay for coverage from the date Your continued benefits begin through the last day of the month in which the initial payment is made. Thereafter, payments for COBRA Coverage must be made monthly and must be remitted on or before the first day of each month during the continuation period. However,

if the monthly Premium payment is less than the required amount by no more than the lesser of $50 or 10% of the required amount, then the person paying the Premium will be notified and given thirty (30) days to pay the additional amount.

COBRA TERMINATING EVENTS

COBRA provides that COBRA Coverage may be cut short for any of the following reasons:

The employer no longer provides group health coverage to any of its employees;

- The Premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered under another group health Plan;
- The qualified beneficiary becomes entitled to Medicare; or
- The qualified beneficiary extends coverage for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. Contact the Plan changes of address. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator or HSB.

IF YOU HAVE COBRA QUESTIONS

If You have questions about Your COBRA Coverage, You should contact:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

Or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

STATE CONTINUATION AND CONVERSION COVERAGE

STATE CONTINATUION COVERAGE OVERVIEW

If the Group Agreement remains in effect, but Your coverage under this EOC would otherwise terminate, the Group may offer You the right to continue coverage for a limited period of time according to State law. If You are eligible for COBRA Coverage, You may elect either COBRA Coverage or State Continuation Coverage, but not both.

ELIGIBILITY

You are eligible if You have been continuously covered under this Plan, or a health Plan that this Plan replaced, for at least 6 months prior to the date of termination of Your coverage under the Group Agreement, for any reason except for nonpayment of required contribution.

You are not eligible if: You were entitled under Federal law to continuation coverage for a period greater than what is provided in this section; You are eligible for other group coverage that provides benefits similar to this Plan; or if You are eligible for Medicare benefits.

ENROLLING FOR STATE CONTINUATION COVERAGE

The group will notify Members eligible for State Continuation Coverage about how to enroll for such coverage on or before the date their coverage would otherwise terminate under the Group Agreement. You must request State Continuation Coverage, in writing, and pay the Premium for that coverage, in advance, as required by the Group.

PREMIUM PAYMENT

You must pay the monthly Premium for State Continuation Coverage to the Group at the time and place specified by the Group.

SECONDARY COVERAGE

Any benefits, except extended benefits payable by the Plan during the period of continuation, are considered secondary to benefits under any other group health Plan that is in force on You during this continuation period.

COVERAGE PROVIDED

Members enrolled for State Continuation Coverage will continue to be covered under the Group Agreement and this EOC, for the rest of the month during which coverage under the Group Agreement would end and 6 additional months.

TERMINATION OF STATE CONTINUATION COVERAGE

State Continuation Coverage will terminate upon the earliest of the following: the end of the applicable period specified above; the end of the period for which You paid the Premium for coverage; or the termination date of the Group Agreement; or the date You become eligible for coverage under another group health benefits Plan; or the date You become entitled to Medicare coverage.

CONVERSION COVERAGE

If Your coverage under this Plan terminates for any reason other than: You fail to pay a required Premium; You become eligible for Medicare; or the Group Agreement is replaced by similar group coverage within 31 days; You may be eligible for conversion to Individual coverage. This provision does not continue coverage under the Group Agreement. Conversion coverage is individual health care coverage from the Plan. Conversion coverage shall be:

- The type of individual coverage offered to converting members as of the date of the termination of their coverage under the Group Agreement;
- Issued without evidence of insurability; and
- Effective as of the date of the termination of Your group coverage. The Plan shall provide an enrollment form and information about that conversion coverage upon written request from You. You must submit a completed enrollment form and the Premium for conversion coverage to the Plan, within 31 days after the termination of Your coverage under the Group Agreement.

GENERAL INFORMATION

GENERAL INFORMATION

CREDITABLE COVERAGE UNDER HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Your employer must issue a "certificate of creditable coverage", in writing, free of charge:

- when You lose coverage under the Plan;
- when You become entitled to elect COBRA;
- when Your COBRA coverage ends;
- if You request a certificate of credible coverage before losing coverage; or
- if You request a certificate of credible coverage up to twenty-four (24) months after losing coverage.

"Creditable Coverage" means health care coverage under any of the types of Plans listed below, during which there was no break in coverage of sixty-three (63) consecutive days or more:

- a group health Plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their Dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health Plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any health coverage provided by a governmental entity;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit Plan under the Peace Corps Act.

If You or Your Eligible Dependents were covered by any of the above Plans before first becoming covered by this Plan, You should have received a Certificate of Creditable Coverage when that Plan's coverage ended.

You may request a certificate of creditable coverage under this Plan by contacting the Plan at the number on Your ID card.

PRIVACY NOTICE FOR THE PLAN

The Privacy Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the notice carefully.

HIPAA PRIVACY NOTICE

This Privacy Notice describes how the Plan may use and disclose Your health information to carry out treatment, payment and health care operations and for other uses and disclosures that are required or permitted by law. If You receive benefits under the Health Plan, this Privacy Notice explains the rights You have with respect to Your health information, and certain obligations the Health Plan must abide by in accordance with the law.

The Health Plan is required by law to maintain the privacy of Your health information and to provide You with this Privacy Notice outlining its legal duties and privacy practices with respect to Your health information. Nothing contained in this Privacy Notice should be construed to supersede or limit any additional rights You may be entitled to under other applicable law. Therefore, if an applicable law affords You greater rights or more protections, the Health Plan will comply with the law that gives You greater rights and/or protections.

The Health Plan is required to abide by the terms of this Privacy Notice, but reserves the right to make additional changes to this Privacy Notice and to make such changes applicable to all of Your health information that it maintains. If the Health Plan makes any material revisions to this Privacy Notice, it will provide You with a copy of the revised Privacy Notice which will specify the date on which such revised Privacy Notice becomes effective.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The Health Plan may use Your health information for treatment, payment and health care operations. The Health Plan may also use Your health information for other purposes that are permitted and/or required by law and pursuant to Your written authorization.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the Health Plan will be required to limit its distribution, use or requests

for protected health information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use. The Secretary of HHS shall issue guidance on what constitutes minimum necessary for the purposes of this provision no later than 18 months following the enactment date. The enactment date is February 17, 2009.

The following lists examples of how the Health Plan may use and/or disclose Your health information. Any other uses or disclosures not described in this Privacy Notice will only be made with Your explicit written authorization, which authorization You may revoke at any time by providing the Health Plan with written notice of Your revocation.

A. For Treatment.
The Health Plan may disclose Your health information to a health care provider that provides treatment to You. For example, in an emergency situation, the Health Plan may provide Your health care provider with information regarding the type of prescription drugs You are currently taking if necessary for Your proper treatment.

B. For Payment.
The Health Plan may use Your health information to obtain Premium payments or to fulfill its responsibility for coverage and the provision of benefits under the Health Plan. For example, the Health Plan may receive and maintain information about a health care service You received in order to process a claim from a physician for reimbursement for services provided to You.

C. For Health Care Operations.
The Health Plan may also disclose Your health information for management functions. For example, the Health Plan may use and/or disclose Your health information to evaluate its performance or to conduct or arrange for legal services and audit functions, including fraud and abuse detection and compliance programs. Additionally, the Health Plan may use Your health information for its business management and general administrative activities, including but not limited to: (i) management activities relating to implementation of and compliance with law; (ii) customer service; (iii) resolution of internal grievances; (iv) the sale, transfer, merger, or consolidation of all or part of the Health Plan with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and (v) creating de-identified information or a limited data set.

D. For Treatment Alternatives.
The Health Plan may use and disclose Your health information to tell You about treatment options or alternatives that may be of interest to You.

E. For Health-Related Benefits and Services.
The Health Plan may use and disclose Your health information to tell You about health-related benefits or services that may be of interest to You.

F. To Family Members, Relatives or Close Friends.
Unless You object to such disclosure, the Health Plan may disclose Your health information to Your family members, relatives or close personal friends, or any other person identified by You as being involved in Your treatment or payment for Your medical care. If You are not present to agree or object to the Health Plan's disclosure of Your health information to a family member, relative or friend, the Health Plan may exercise its professional judgment to determine whether the disclosure is in Your best interest. If the Health Plan decides to disclose Your health information to Your family member, relative or other individual identified by You, the Health Plan will only disclose the health information that is relevant to Your treatment or payment.

G. To Business Associates.
The Health Plan may disclose Your health information to its "business associates." Third party administrators, auditors and consultants are some examples of business associates of the Health Plan.

H. Other Permitted and Required Uses and Disclosures.
In some cases, the Health Plan may use Your health information without obtaining Your authorization and without offering You the opportunity to agree or object as follows:

- as required by law, provided however, that the use or disclosure will be made in compliance with applicable law;
- to a public health authority that is authorized by law to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority;
- to a health oversight agency for oversight activities authorized by law, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions;
- to a public health authority or to a government authority authorized by law to receive reports of abuse, neglect or domestic violence;
- for judicial or administrative proceedings;
- for law enforcement purposes;

- to a coroner or medical examiner to perform duties authorized by law;
- to funeral directors, consistent with applicable law, as necessary to carry out their duties;
- to organ procurement organizations or similar entities for the purpose of facilitating organ, eye or tissue donation and transplantation;
- for research purposes;
- to avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such threat;
- for specialized government functions, such as the proper execution of a military mission or national security activities;
- to a correctional institution or law enforcement custodian;
- to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault; and
- to the Plan sponsor of the Health Plan as permitted by law.

YOUR RIGHTS AS A PARTICIPANT IN THE HEALTH PLAN

As a participant in the Health Plan, You have a number of rights associated with Your health information. The following describes Your specific rights.

A. The Right to Request a Restriction or Limit on the Use and Disclosure of Your Health Information.

You have the right to request restrictions or limits on how the Health Plan is allowed to use and/or disclose Your health information, however, the Health Plan does not have to agree to Your requested restriction or limit. If You would like to request a restriction or limit on the Health Plan's use or disclosure of Your health information, please send Your written request to the address listed at the end of this Privacy Notice. Your request must specify: (1) if You would like to restrict or limit Health Plan's use, disclosure or both; (2) what information You would like to restrict or limit; and (3) to whom You want the limit or restriction to apply (e.g., Your spouse).

If the Health Plan agrees to a restriction or limit of Your health information, the restriction or limit will not prevent the Health Plan from disclosing Your health information as follows: (1) to You if You request access to Your health information or if You request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to workers' compensation); or (3) in the case of an emergency.

If the Health Plan accepts Your restriction or limit regarding how the Health Plan may use or disclose Your health information, the Health Plan may nevertheless disclose the restricted health information to a health care Provider if You are in need of emergency care and Your restricted health information is needed to provide emergency treatment to You. Before the Health Plan discloses Your restricted health information to a health care Provider during an emergency, the Health Plan will require the health care Provider that receives Your health information to not further use or disclose Your health information.

If the Health Plan accepts Your requested restriction or limit, it may terminate the restriction or limit if: (1) You agree to the termination or request the termination in writing; (2) You orally agree to the termination and the oral agreement is appropriately documented; or (3) it informs You that it is terminating the restriction or limit; provided, however, the Health Plan's termination would only be effective for health information the Health Plan creates or receives after it informs You of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations.

You have the right to request receipt of health information from the Health Plan by alternative means or via alternative locations provided that You clearly state that the disclosure of all or part of Your health information could endanger You. For example, You may want to receive communications related to Your health care at a different address other than Your home address because You could be in danger of harm if someone at that address saw Your health information. If You wish to receive confidential communications via alternative means or locations, please submit Your written request to the address listed at the end of this Privacy Notice and set forth the alternative means by which You wish to receive communications or the alternative location at which You wish to receive such communications.

C. Right to Inspect and Copy Your Health Information.

You have the right to inspect and obtain a copy of Your health information; provided, however, You are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 ("CLIA") to the extent Your access is prohibited by law, or is exempt from CLIA. If You would like to access Your health

information, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. If You request a copy of Your health information, You will receive a response to Your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, the Health Plan may deny Your request for access to health information. For example, the Health Plan may deny access to health information that is subject to the Privacy Act. The Health Plan may also deny You access to health information if such information was obtained from someone other than a health care Provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. If Your request is denied for one of these reasons, You will not have the opportunity to review the denial.

Additionally, the Health Plan may deny You access to health information if: (1) access is reasonably likely to endanger the life and physical safety of You or someone else; (2) the access requested refers to another person and Your access is reasonably likely to cause substantial harm to such other person; or (3) You are the personal representative of another individual and a health care professional determines that Your access is reasonably likely to cause substantial harm to the individual or another person. If You are denied access for one of these reasons, You are entitled to review by a health care professional, designated by the Health Plan, who was not involved in the decision to deny access. If access is ultimately denied, You will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures.

You have the right to receive an accounting of disclosures of Your health information made by the Health Plan, including disclosures to or by business associates of the Health Plan, for the period of six years prior to the date on which You request an accounting of disclosures, or such lesser period as You indicate; provided, however, You are not entitled to receive an accounting of disclosures for disclosures that occurred prior to April 14, 2004. If You would like to receive an accounting of disclosures, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when it receives Your request. You will receive a response to Your request for an accounting of disclosures no later than sixty days after Your request is received.

Notwithstanding the foregoing, Your accounting of disclosures will not include any disclosures made: (1) to carry out treatment, payment and/or health care operations; (2) directly to You; (3) incident to a use or disclosure permitted by law; (4) pursuant to Your authorization; (5) to persons involved in Your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2004.

To the extent the Health Plan uses or maintains Electronic Health Records (EHRs), the Health Plan must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years. You have a right to obtain a copy of the record in an electronic format and to direct the Health Plan to transmit a copy of the record to any entity or person designated by You. This provision is effective January 1, 2011 or the date EHR is acquired for all EHRs acquired after January 1, 2009. For EHRs acquired on or before January 1, 2009, the provision will be effective January 1, 2014.

You will receive one request annually free of charge and, thereafter, the Health Plan may charge You a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same twelve-month period. The Health Plan will notify You of the cost for an accounting of disclosures and You may choose to withdraw or modify Your request before it charges You for any costs.

E. Right to Amend Your Health Information.

If You believe the Health Plan has health information about You that is incorrect or incomplete, You may make a written request to the Health Plan stating the reasons to support Your requested amendment. You have the right to request an amendment to Your health information for so long as the Health Plan maintains Your health information. If You would like to amend Your health information, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. You will receive a response to Your request for an amendment no later than sixty days after the Health Plan receives Your request. However, the Health Plan may deny Your request for amendment if, for example, the

Health Plan determines that it did not create Your health information or Your health information is already accurate and complete. You may respond to a denial by the Health Plan by filing a written statement of disagreement, but the Health Plan has the right to rebut Your disagreement. If this occurs, You have the right to request that Your original request, the Health Plan's denial, Your statement of disagreement, and the Health Plan's rebuttal be included in future disclosures of Your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice.
You have the right at any time to obtain a paper copy of this Privacy Notice, even if You receive this Privacy Notice electronically. If You have received an electronic copy of this Privacy Notice, but would like to obtain a paper copy of this Privacy Notice, please send Your written request to the address listed at the end of this Privacy Notice.

MISCELLANEOUS

A. Complaints.
If You believe Your privacy rights have been violated, You may file a complaint through Customer Service by calling the number on the ID card.

You can also file a complaint with the Tennessee Department of Insurance; however, such complaints are separate from and in addition to, the Appeals processes in this EOC.

If You would like to file a complaint with the Health Plan, please forward Your written complaint to the address listed at the end of this Privacy Notice. If You choose to file a complaint, the Health Plan is prohibited by law from retaliating against You for filing such complaint.

B. Breach.
The Covered Entity is required to notify each individual whose unsecured protected health information is the subject of a breach, or is reasonably believed to be subject of a breach. Notification must occur within 60 days of the discovery of the breach. In addition, the Health Plan must notify the Secretary of the Department of Health and Human Services. If the breach involves 500 or more individuals, the Covered Entity is also required to notify a local media outlet serving the state or jurisdiction in which the individuals reside.

This provision is effective 180 days after the enactment date. The enactment date is February 17, 2009.

C. Effective Date.
This revised notice is effective as of January 1, 2014.

D. Contact Information.
If You need any additional information about this Privacy Notice, please contact, the Privacy Officer, Community Health Alliance
445 South Gay St.
Knoxville, TN 37902.

GENETIC INFORMATION

The Plan operates in compliance with the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) ("GINA"), which prohibits group health Plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, You are entitled to certain rights and protections under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). Because the HSAs are not welfare benefit Plans subject to ERISA, these rights and protections do not apply to the HSAs. Except with respect to Your HSA, You have the right to:

- examine, without charge, at the Plan s office and at other specified locations, all Plan documents, including insurance contracts and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- obtain copies of all Plan documents and other Plan information upon written request to the Plan. The Plan may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant in a funded Plan with a copy of this summary annual report.
- continue health care coverage for Yourself, Your spouse or Your Dependents if there is a loss of coverage under a health benefit Plan as a result of a qualifying event. You or Your Dependents may have to pay for such

coverage. Review this summary Plan description and the documents governing the Plan for the rules governing Your COBRA continuation rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plans. The people who operate Your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or discriminate against You in any way in order to prevent You from obtaining a benefit to which You are entitled, or from exercising Your rights under ERISA.

If Your claim for a benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial, and You have the right to have the Plan review and reconsider Your claim (see section entitled, *Appealing a Claim*). Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive them, unless the materials were not sent because of reasons beyond the control of the Administrator.

If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a federal or state court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, You may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the Plan, You should contact Your employer through Your local Human Resources representative. If You are not satisfied with the answers to Your questions, or if You have questions about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

PLAN CHANGES AND TERMINATION

The Plan reserves the right to terminate, suspend, withdraw, amend, or modify the Plan, any portion of the Plan, and this EOC, in whole or in part, at any time and for any reason. The Plan may also change administrators and service providers for the Plan, in its sole discretion. The Plan does not promise the continuation of any benefit, nor does it promise any specific level of benefits, or cost for such benefits.

No one has the authority to make any oral changes to the Plan or this EOC.

GENERAL RESTRICTIONS AGAINST ALIENATION

You may not sell, assign or transfer Your interest in the Plan, except to the extent that the Plan permits assignments of Your benefits to health care providers. The Plan can, however, disburse funds to Your legally appointed guardian, executor, administrator or personal representative. If You declare bankruptcy or anticipate, sell, transfer, assign or encumber a Plan distribution or payment, voluntarily or involuntarily, Your benefit payments can be restricted.

NO EMPLOYMENT RIGHTS

Neither the adoption of the Plan, nor Your status as a Participant in any underlying Plan shall constitute a guarantee of continued employment with the employer. Also, You cannot sell, transfer or assign either voluntarily or involuntarily the value of Your benefit under the Plans.

TAX EFFECT

Neither the Plan nor the Plan Sponsor makes any warranty or other representation as to whether any payments or benefits You receive from the Plan will be treated as includable in gross income for federal or state income tax purposes.

PLAN ADMINISTRATION AND INTERPRETATION

The Plan shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. The Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan

member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

CLAIMS ADMINISTRATOR

The Plan has retained HealthSCOPE Benefits, Inc. to administer and process claims for benefits according to the Plan and consistent with a framework of rules, policies, interpretations, practices and procedures adopted by the Plan.

NAME OF PLAN

The Community Health Alliance Group Benefit Plan.

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ISSUER

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

The Plan Sponsor retains all fiduciary responsibility with respect to the Plan except to the extent the Plan Sponsor has delegated such responsibilities to other persons or entities.

EFFECTIVE DATE OF THIS EOC

January 1, 2014, except as noted in this EOC.

NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF PLAN ADMINISTRATOR

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

DATE OF THE END OF THE YEAR FOR PURPOSES OF MAINTAINING PLAN'S FISCAL RECORDS

The Plan year shall be a twelve month period ending December 31.

GOVERNING LAW

Your benefits will be governed by the laws of the State of Tennessee; however, if the extraterritorial laws of another state apply to Your benefits, Your benefits will be administered accordingly.

AGENT FOR SERVICE OF LEGAL PROCESS

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema.

If You are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Expenses as You determine appropriate care with Your attending Physician:

- Coverage for hospitalization following mastectomy for at least 48 hours, unless Your attending Physician determines early release is appropriate. In the case of early release, at least one home visit will be covered if ordered by Your attending Physician;
- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complication of the mastectomy, including lymphedema.

The amount You must pay for such Covered Expenses, including Plan Year Deductible, are the same as are required for any other Covered Expense. Limits on Benefits are the same as for any other Covered Expense.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health Plans and health insurance issuers generally may not, under Federal or State law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (not including the day of delivery), or less than 96 hours following a cesarean section (not including the day of surgery). However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her coverage and coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave. Check with the Group to see if this provision applies.

KEY TERMS AND DEFINITIONS

The following terms or phrases are used throughout the EOC. These terms or phrases have special meaning.

ADVERSE DETERMINATION

Means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed; and, based upon the information provided:

- Does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness; or
- Is Experimental or Investigational and involves a condition that is life threatening or seriously disabling.

ALLOWED AMOUNT

Means the maximum amount on which payment is based for Covered Expenses or Covered Benefits. If Your Non-Network Provider charges more than the Allowed Amount, You may have to pay the difference.

APPEAL

Means a request for the Plan to review a decision again.

AUTHORIZED REPRESENTATIVE

Means:

- A person to whom a covered person has given express written consent to represent the covered person in an external review;
- A person authorized by law to provide substituted consent for a covered person; or
- A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

AUTISM SPECTRUM DISORDERS

Means neurological disorders, usually appearing in the first 3 years of a person's life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BALANCE BILLING

When a Provider bills You for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill You for the remaining $30. A Network Provider should not balance bill You for Covered Services. Contact Customer Service if You have questions about how much You may owe.

BIRTHING CENTER

Means an inpatient or outpatient facility which:

- complies with all legal requirements in the jurisdiction where it is located;
- primarily provides a comprehensive Birth Services program to pregnant individuals who are considered normal low risk patients;
- has organized facilities for Birth Services on its premises;
- has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a nurse midwife; and
- has 24-hour-a-day Registered Nurse Services.

BIRTH SERVICES

Means antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor; and 2) spontaneous vaginal delivery.

CLINICAL REVIEW CRITERIA

Means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

COINSURANCE

Means Your share of the costs of a Covered Service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. You pay coinsurance plus any Deductibles You owe. For example, if the Plan's Allowed Amount for an office visit is $100 and You've met Your Deductible, Your coinsurance payment of 20% would be $20. The Plan pays the rest of the Allowed Amount.

COMPLICATIONS OF PREGNANCY

Means a condition due to pregnancy, labor and delivery that requires medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section aren't complications of pregnancy.

COPAYMENT

Means a fixed amount (for example, $15) You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

COVERED EXPENSE, COVERED BENEFIT OR COVERED SERVICE

Means the expenses as defined and listed on the section entitled, *What's Covered under the Health Coverage Plan*.

COVERED DEPENDENT

Means an Eligible Dependent whose coverage under the Plan: 1) became effective; and 2) has not terminated.

COVERED EMPLOYEE

Means an Eligible Employee whose coverage under the Plan: 1) became effective, and 2) has not terminated.

COVERED PERSON

Means an Eligible Employee and Eligible Dependent whose coverage under the Plan: 1) became effective; and 2) has not terminated.

DEDUCTIBLE

Means the amount You owe for Covered Services before the Plan begins to pay. For example, if Your Deductible is $1,000, the Plan won't pay anything until You've met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible may not apply to all services.

DRUG

Means a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or component, part or accessory of a device; biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process.

DURABLE MEDICAL EQUIPMENT

Means equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for Durable Medical Equipment may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

ELIGIBLE DEPENDENT

Means a Dependent who meets the eligibility requirements under the Plan. Refer to the *Dependent Eligibility* section on page 3 under *Eligibility and Enrollment* for the specific definition.

ELIGIBLE EMPLOYEE

Means an employee who meets the eligibility requirements under the Plan. Refer to the *Eligibility* section for the specific definition.

EMERGENCY CARE

Means medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL CONDITION

Means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL TRANSPORTATION

Means ambulance services for an Emergency Medical Condition.

EMERGENCY ROOM CARE

Means Emergency Services You get in an Emergency Room.

EMERGENCY SERVICES

Means evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

ESSENTIAL HEALTH BENEFITS

Means, under section 1302(b) of the Patient Protection and Affordable Care Act, as amended from this time to time, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease

management; and pediatric services, including oral and vision care.

EXCLUDED SERVICES

Means health care services the Plan doesn't pay for or cover.

EXPERIMENTAL / INVESTIGATIONAL SERVICES

Means at the time a determination is made regarding coverage in a particular case, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will be determined to be "Investigative" if reliable, authoritative evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis.

The Plan will base its determination upon an examination of one or more of the following kinds of reliable evidence, none of which shall be determinative in and of itself:

- Published reports, articles, or consensus expert panel opinions and recommendations in the authoritative peer reviewed medical and scientific literature
- Written protocol(s) used by the treating Provider; or the protocol(s) of another Provider studying substantially the same service; or the written informed consent used by the treating Provider or by another Provider studying substantially the same service
- Review by a financially disinterested, external, specialty appropriate board-certified expert medical reviewer

All determinations of reliable evidence shall be made by the Plan.

Notwithstanding the above, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will not be determined to be "investigative" and will be considered a covered benefit when it is being administered or performed as part of a Phase III clinical investigational trial where all treatment arms involve Covered Services for covered conditions. In addition, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

FACILITY

Means an institution providing health care services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

FINAL ADVERSE DETERMINATION

Means an adverse determination involving a covered benefit that has been upheld at the completion of the internal Appeal process.

GRIEVANCE

A complaint that You communicate to the Plan.

GROUP AGREEMENT OR AGREEMENT

Means the arrangements between the Plan and the Group including this EOC, the Plan Sponsor Group Application, any Riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.

GROUP OR PLAN SPONSOR

Means a corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide coverage to its employees and their Eligible Dependents.

HABILITATION SERVICES

Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH INSURANCE

Means a contract that requires Your health insurer to pay some or all of Your health care costs in exchange for a Premium.

HEALTH INSURANCE COVERAGE

Means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service Plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Credit only insurance;
- Coverage for onsite medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- If offered separately: limited scope dental or vision benefits, benefits for long term care, nursing home care, home health care, community based care, or any combination of these, or other similar, limited benefits as are specified in regulations;
- If offered as independent, noncoordinated benefits;
- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance;
  If offered as a separate insurance policy: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code, and similar supplemental coverage under a group health Plan.

HOME HEALTH CARE

Means health care services a person receives at home.

HOME HEALTH CARE AGENCY

Means a public or private agency that provides skilled nursing functions or activities in the Covered Person's home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

HOSPITAL

Means an institution which:

- is legally operated in the jurisdiction where it is located;
- is engaged mainly in providing inpatient medical care and treatment for Injury and Illness/Sickness in return for compensation;
- has organized facilities for diagnosis and major surgery on its premises;
- is supervised by a staff of at least two Physicians;
- has 24-hour-a-day nursing service by Registered Nurses; and
- is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or Skilled Nursing Facility or similar institution; or a Long Term Acute Care Facility (LTAC).

HOSPICE SERVICES

Means services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITALIZATION

Means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

HOSPITAL OUTPATIENT CARE

Means care in a Hospital that doesn't require an overnight stay.

ILLNESS

Means a sickness or a disease of a Covered Employee or Covered Dependent. Illness will include congenital defects or birth abnormalities.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of

Adverse Determinations and final Adverse Determinations.

IN-NETWORK COINSURANCE

Means the percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who contract with Your Plan.

IN-NETWORK COPAYMENT

Means a fixed amount (for example, $15) You pay for Covered Services to Providers who contract with Your Plan.

INJURY

Means accidental bodily injury of a Covered Employee or Covered Dependent.

INTENSIVE CARE UNIT

Means a section, ward or wing within the Hospital which:

- is separated from other Hospital facilities;
- is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
- provides room and board; and
- provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

LICENSED PRACTICAL NURSE

Means an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service. This definition will include licensed vocational nurses with the above qualifications.

LIFE THREATENING CONDITION OR DISEASE

Means a condition or disease which, according to the current diagnosis by the Covered Person's treating Physician, has a high probability of causing the Covered Person's death.

MAXIMUM OUT OF POCKET (MOOP)

Means the most You pay during a policy period (usually a year) before the Plan begins to pay 100% of the Allowed Amount. This limit never includes Your Premiums, balance-billed charges or health care Your Plan doesn't cover.

MEDICAL AND SCIENTIFIC EVIDENCE

Means:

- peer reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research;
- medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;
- these standard reference compendia: the American Hospital Formulary Service Drug Information, the American Medical Association Drug Evaluation the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia Drug Information;
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

MEDICALLY NECESSARY

Means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

MEMBER, YOU, YOUR

Means any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.

NETWORK

Means the facilities, providers and suppliers Your Plan has contracted with to provide health care services.

NETWORK PROVIDER

Means a participating Provider that the Preferred Provider network or

one of its rental networks have contracted with or made arrangements with to provide health services to Covered Persons. A Network Provider has agreed to charge participants a discounted rate. To determine if a Provider is a Network Provider log onto www.chatn.org and click the *Find a Provider* tab. You may also call the number on Your ID card and a Customer Service representative can locate a Network Provider for You. A provider list based on Your zip code will be sent to You, free of charge, upon Your request.

The term Provider means a Physician, eligible professional provider, Hospital and eligible health care facility provider.

OUT-OF-NETWORK PROVIDER

An Out-of-Network Provider is a Provider not under contract as a Network Provider either with the Covered Person's PPO network or a reciprocal network. No benefits or payments are available for services received from and Out of Network Provider, even if the services would otherwise be deemed Covered Services, except in the case of a true Emergency.

PHYSICIAN

Means a person who has successfully completed the prescribed course of studies in medicine in a medical school officially recognized and who has acquired the requisite qualifications for license in the state in which the treatment is received in the practice of medicine. He or she must be practicing within the scope of that license.

PHYSICIAN SERVICES

Means health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

PLAN

Means a benefit Your employer, union, or other group sponsor provides to You to pay for Your health care services.

PLAN YEAR

Means a 12-month period of time that follows the Plan's Effective Date and each subsequent twelve-month period this Plan remains in force.

PRACTITIONER

A professional who provides health care services. Practitioners are usually licensed as required by law.

PREAUTHORIZATION

Means a decision by Your Plan that a health care service, treatment Plan, prescription drug, or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or precertification. Your Plan may require preauthorization for certain services before You receive them, except in an emergency. Preauthorization isn't a promise Your Plan will cover the cost.

PREFERRED PROVIDER

Means a Provider who has a contract with Your Plan to provide services to You at a discount. Check the Plan to see if You can see all Preferred Providers or if Your Plan has a "tiered" network and You must pay extra to see some providers. Your Plan may have Preferred Providers who are also "participating" Providers. Participating Providers also contract with Your Plan, but the discount may not be as great, and You may have to pay more.

PREMIUM

Means the amount that must be paid for Your Plan. You and/or Your Plan Sponsor usually pay it monthly, quarterly or yearly.

PRESCRIPTION DRUG

Means a drug that can be dispensed to the public only with an order given by a properly authorized person. The designation of a medication as a prescription drug is made by the U.S. Food and Drug Administration.

PRESCRIPTION DRUG COVERAGE

Means Health Insurance or Plan that helps pay for Prescription Drugs and medications.

PRESCRIPTION DRUG PRODUCT

A prescription drug product requires a doctor's authorization to purchase.

PRIMARY CARE PHYSICIAN

Means a Physician, including a Pediatrician or OB/GYN(M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

PRIMARY CARE PROVIDERS

Means a Physician, including a Pediatrician or OB/GYN (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

PROVIDER

Means a Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

QMCSOs are state court orders requiring a parent to provide

medical support to a child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to Your child even though, for income tax or Plan purposes, the child is not Your Dependent. To qualify, a QMCSO must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- specifies Your last known name and address and the child's last known name and address,
- describes the type of coverage to be provided, or how the type of coverage will be determined,
- states the period to which it applies, and
- specifies each Plan to which it applies.
- The QMCSO cannot require the Plans to cover any type or form of benefit that they do not currently cover. The Plans must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions.
- You and the affected child will be notified if an order is received and will be provided, free of charge, with a copy of Your Plan Sponsor's QMCSO procedures.

RECONSTRUCTIVE SURGERY

Means surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

REGISTERED NURSE

Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided.

REHABILITATION SERVICES

Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

REIMBURSABLE PAYMENTS

Means payments made by this Plan for health care benefits that are or become the responsibility of another party under the subrogation provisions of this EOC.

SERIOUS MEDICAL CONDITION

Means a health condition of illness that requires immediate medical attention where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SERIOUSLY DISABLING

Means a health condition or illness that involves a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SKILLED NURSING CARE

Means services from licensed nurses in Your own home or in a nursing home. Skilled care services are from technicians and therapists in Your home or in a nursing home.

SPECIALIST

Means a physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician Specialist is a Provider who has more training in a specific area of health care.

SUBSCRIBER

Means an Employee who meets all applicable eligibility requirements, has enrolled or coverage and for whom the Plan has received the applicable Premium for coverage from the Group.

URGENT CARE CENTER

Means a facility operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

USUAL AND CUSTOMARY

Means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The Usual and Customary amount as determined at the sole discretion of the Health Plan sometimes is used to determine the Allowed Amount.

URGENT CARE

Means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes to the Plan. Generally, Plan changes are announced each year in the fall during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If You see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Employee	
Family	
Plan Year Out-of-Pocket Maximum (Excludes Deductible)	
Employee	
Family	
Maximum Benefit Limit Per Covered Individual for:	
Transplants	

	In-Network
Accidental Dental Care	
Acupuncture	
Ambulance	
Asthma	
Chiropractic Care	
Contraceptive Services	
CT, MRI and PET scan	
Durable Medical Equipment	
Emergency Room	
Home Healthcare	
Home Infusion Therapy	
Hospice Care	
Infertility	
Inpatient Hospital Care	
Inpatient Rehabilitations	
Lab and X-Ray	
Maternity Care	
Medical Supplies	
Mental Health Inpatient & Outpatient Services	
Nutritionist	
Occupational Therapy	
Office Visits	
Oral Surgery	
Outpatient Hospital Care	
Physical Therapy	
Physician Services	
Preventive Care Services	

Prescription Drugs	
Retail	
Mail Order or from a retail pharmacy	
Radiation Therapy Chemotherapy	
Skilled Nursing Facility	
Speech Therapy	
Substance Abuse Inpatient & Outpatient Care	
TMJ	
Transplants	
Urgent Care	
All Other Covered Expenses	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$250
Family	$500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$2,250
Family	$4,500
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$15 Copay
Specialist Office Visit	$40 Copay
Other Practitioner	$15 Copay
Prenatal and Postnatal Care	$40 Copay
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	$15 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$40 Copay
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay In Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	10% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible – Out-of-Network
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period
Emergency Room Services	$250 Copay – In Network 10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $25 Copay
	Non-Preferred Brand Drugs - $50 Copay
	Specialty Drugs – 10% Coinsurance
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order
	Non-Preferred Brand Drugs - $150 Copay, Retail; $100, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$500
Family	$1,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,500
Family	$9,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$50 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay In-Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	$100 Copay + 20% Coinsurance In Network or Out-of-Network
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 20% Coinsurance
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 20% Coinsurance
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Transplants	20% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$1,250
Family	$2,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$4,500
Family	$9,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$20 Copay
Specialist Office Visit	$50 Copay
Other Practitioner	$20 Copay
Prenatal and Postnatal Care	$50 Copay
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible
Office Laboratory	0% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	20% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay In-Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	$100 Copay + 20% Coinsurance In Network or Out-of-Network
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

Rehabilitative Speech Therapy	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance Limit of 20 Visits per Calendar Year
Prosthetic Devices	20% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $30 Copay
	Non-Preferred Brand Drugs - $60 Copay
	Specialty Drugs – 20% Coinsurance
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order
	Specialty Drugs – 20% Coinsurance
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Transplants	20% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$ 6,350
Family	$12,800
Coinsurance	30% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$25 Copay
Specialist Office Visit	$55 Copay
Other Practitioner	$25 Copay
Prenatal and Postnatal Care	$55 Copay
Family Planning and Reproductive Services	30% Coinsurance after Deductible
Chiropractic Care	$20 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	0% Coinsurance
Office Laboratory	0% Coinsurance
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$55 Copay
Services Received at a Facility	
Outpatient Facility Fee	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	30% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	$55 Copay In-Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	$150 Copay + 30% Coinsurance In Network or Out of Network
Durable Medical Equipment	30% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible

Rehabilitative Speech Therapy	$55 Copay Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	$55 Copay Limit of 20 Visits per Calendar Year
Prosthetic Devices	30% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $35 Copay
	Non-Preferred Brand Drugs - $65 Copay
	Specialty Drugs – 30% Coinsurance
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $105 Copay, Retail; $70 Copay, Mail Order
	Non-Preferred Brand Drugs - $195 Copay, Retail; $130, Mail Order
	Specialty Drugs – 30% Coinsurance
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Transplants	30% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network
Deductibles	
Individual	$2,000
Family	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$ 6,350
Family	$12,800
Coinsurance	40% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$35 Copay
Specialist Office Visit	40% Coinsurance after Deductible
Other Practitioner	$35 Copay
Prenatal and Postnatal Care	$35 Copay
Family Planning and Reproductive Services	40% Coinsurance after Deductible
Chiropractic Care	$35 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible
Office Laboratory	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible
Diabetic Care Management	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	40% Coinsurance after Deductible
Dental Anesthesia	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	40% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible

Skilled Nursing Facility	40% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	40% Coinsurance after Deductible In-Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible
Reconstructive Surgery	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	40% Coinsurance after Deductible
Home Health Care Services	40% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible
Hearing Aids	40% Coinsurance after Deductible

Rehabilitative Speech Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	40% Coinsurance after Deductible
Clinical Trials	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay
	Preferred Brand Drugs - $40 Copay
	Non-Preferred Brand Drugs - $75 Copay
	Specialty Drugs – 40% Coinsurance
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order
	Specialty Drugs – 40% Coinsurance
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Transplants	40% Coinsurance after Deductible
	Pre-certification required

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	In-Network
Deductibles	
Individual	$4,000
Family	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$ 6,350
Family	$12,800
Coinsurance	40% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	$30 Copay
Specialist Office Visit	40% Coinsurance after Deductible
Other Practitioner	$30 Copay
Prenatal and Postnatal Care	$0 Copay
Family Planning and Reproductive Services	40% Coinsurance after Deductible
Chiropractic Care	$30 Copay
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible
Office Laboratory	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible
Diabetic Care Management	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	40% Coinsurance after Deductible
Dental Anesthesia	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$0 Copay
Services Received at a Facility	
Outpatient Facility Fee	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	40% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible

Skilled Nursing Facility	40% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	40% Coinsurance after Deductible In-Network or Out-of-Network
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible
Reconstructive Surgery	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	40% Coinsurance after Deductible
Home Health Care Services	40% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period
Emergency Room Services	40% Coinsurance after Deductible
Durable Medical Equipment	40% Coinsurance after Deductible

Hearing Aids	40% Coinsurance after Deductible
Rehabilitative Speech Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	40% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	40% Coinsurance after Deductible
Clinical Trials	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 40% Coinsurance after Deductible
	Preferred Brand Drugs - 40% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 40% Coinsurance after Deductible
	Specialty Drugs – 40% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 40% Coinsurance after Deductible, Retail; 40% Coinsurance after Deductible, Mail Order
	Preferred Brand Drugs - 40% Coinsurance after Deductible,Retail; 40% Coinsurance after Deductible, Mail Order
	Non-Preferred Brand Drugs - 40% Coinsurance after Deductible,Retail; 40% Coinsurance after Deductible, Mail Order
	Specialty Drugs – 40% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Transplants	40% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$1,500
Family	$3,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$3,000
Family	$6,000
Coinsurance	10% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	10% Coinsurance after Deductible
Specialist Office Visit	10% Coinsurance after Deductible
Other Practitioner	10% Coinsurance after Deductible
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Family Planning and Reproductive Services	10% Coinsurance after Deductible
Chiropractic Care	10% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	10% Coinsurance after Deductible
Office Laboratory	10% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	10% Coinsurance after Deductible
Diabetic Care Management	10% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	10% Coinsurance after Deductible
Dental Anesthesia	10% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	10% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	10% Coinsurance after Deductible
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible

Skilled Nursing Facility	10% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Habilitation Services	10% Coinsurance after Deductible
Urgent Care Centers or Facilities	10% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	10% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	10% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	10% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	10% Coinsurance after Deductible
Reconstructive Surgery	10% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	10% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	10% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	10% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	10% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	10% Coinsurance after Deductible
Home Health Care Services	10% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible

Rehabilitative Speech Therapy	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Rehabilitative Occupational and Rehabilitative Physical Therapy	10% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	10% Coinsurance after Deductible
Clinical Trials	10% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 10% Coinsurance after Deductible
	Preferred Brand Drugs - 10% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 10% Coinsurance after Deductible
	Specialty Drugs – 10% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 10% Coinsurance after Deductible, Retail; 10% Coinsurance after Deductible, Mail Order
	Preferred Brand Drugs - 10% Coinsurance after Deductible, Retail; 10% Coinsurance after Deductible, Mail Order
	Non-Preferred Brand Drugs - 10% Coinsurance after Deductible, Retail; 10% Coinsurance after Deductible, Mail Order
	Specialty Drugs – 10% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	10% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	10% Coinsurance after Deductible
Transplants	10% Coinsurance after Deductible
	Pre-certification required

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network
Deductibles	
Individual	$1,750
Family	$3,500
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.
Individual	$5,250
Family	$10,500
Coinsurance	20% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network** **All coinsurance shown after Deductible unless otherwise specified** **Subscriber Pays:**
Services Received at a Practitioner's Office	
Office Services for Preventive Care	
Preventive Care/ Screening/ Immunization	$0 Copay
Well Woman Exam	$0 Copay
Screening Mammogram	$0 Copay
Prostate Cancer Screening	$0 Copay
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury	
Primary Care Office Visit	20% Coinsurance after Deductible
Specialist Office Visit	20% Coinsurance after Deductible
Other Practitioner	20% Coinsurance after Deductible
Prenatal and Postnatal Care	20% Coinsurance after Deductible
Family Planning and Reproductive Services	20% Coinsurance after Deductible
Chiropractic Care	20% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year
X-rays and Diagnostic Imaging	20% Coinsurance after Deductible
Office Laboratory	20% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	20% Coinsurance after Deductible
Services Received at a Facility	
Outpatient Facility Fee	20% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible
Inpatient Physician and Surgical Services	20% Coinsurance after Deductible

Skilled Nursing Facility	20% Coinsurance after Deductible Limit of 60 Days per Benefit Period
Outpatient Rehabilitation Services	20% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
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Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible
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Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible
Other Services	
Emergency Transport/Ambulance	20% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible Limit of 60 Visits per Benefit Period
Emergency Room Services	20% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible

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Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 20% Coinsurance after Deductible
	Preferred Brand Drugs - 20% Coinsurance after Deductible
	Non-Preferred Brand Drugs - 20% Coinsurance after Deductible
	Specialty Drugs – 20% Coinsurance after Deductible
	Immunizations - $0 Copay
	Note: Certain drugs require limitations. See the Formulary for details.
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 20% Coinsurance after Deductible, Retail; 20% Coinsurance after Deductible, Mail Order
	Preferred Brand Drugs - 20% Coinsurance after Deductible, Retail; 20% Coinsurance after Deductible, Mail Order
	Non-Preferred Brand Drugs - 20% Coinsurance after Deductible, Retail; 20% Coinsurance after Deductible, Mail Order
	Specialty Drugs – 20% Coinsurance after Deductible
	Note: Certain drugs have limitations. See the Formulary for details.
Off Label Prescription Drugs	Copay for applicable tier
Mandated Drugs	$0 Copay
Dental Services	20% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible
	Pre-certification required

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Rate Information

Rate data applies to filing.

Filing Method:
Rate Change Type: Neutral
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision:
Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Community Health Alliance Mutual Insurance Company	New Product	%	%				%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

Rate Review Detail

COMPANY:

Company Name: Community Health Alliance Mutual Insurance Company
HHS Issuer Id: 66842
Product Names: Group EPO and POS
Trend Factors:

FORMS:

New Policy Forms: ETN_100_EPO_14, ETN_100_POS_14
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 0
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 0.00
Projected Incurred Claims: 0.00
Annual $: Min: 0.00 Max: 0.00 Avg: 0.00

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		CHA Group On Exchange Rates	ETN_100_EPO_14	New		CHA Group_OnExchange_SERFF Format.xls,

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: CHA Small Group
Project Name/Number: /

Attachment CHA Group_OnExchange_SERFF Format.xls is not a PDF document and cannot be reproduced here.

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: CHA Small Group
Project Name/Number: /

Supporting Document Schedules

Bypassed - Item:	Accident & Health Group Rates non-experience
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Cover Letter Accident & Health
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Description of Variables
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Filing Fees
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Group Rates Certification/Memo - Accident & Health
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	PPACA Uniform Compliance Summary

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: CHA Small Group
Project Name/Number: /

Comments:	
Attachment(s):	Group Compliance Summary.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Third Party Authorization
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	Readibility Certification.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Part III Memorandum CHA Small Group 042613.pdf CHA Small Group - 2014 Actuarial Memorandum revised 05062013.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	URRT_CHA_Grp_2013042991736.xml

State: *Tennessee* **Filing Company:** *Community Health Alliance Mutual Insurance Company*
TOI/Sub-TOI: *H16G Group Health - Major Medical/H16G.003G Small Group Only - Other*
Product Name: *CHA Small Group*
Project Name/Number: */*

Item Status:	
Status Date:	

Satisfied - Item:	Modified Plan and Benefits
Comments:	Modified not needed for On Exchange
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Policy Form Id Crosswalk
Comments:	
Attachment(s):	CHA PolicyFormId Crosswalk.xlsx
Item Status:	
Status Date:	

State: Tennessee **Filing Company:** Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: CHA Small Group
Project Name/Number: /

Attachment URRT_CHA_Grp_2013042991736.xml is not a PDF document and cannot be reproduced here.

Attachment CHA PolicyFormId Crosswalk.xlsx is not a PDF document and cannot be reproduced here.

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
				☐ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

Reset Form

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No pre-ex listed			
	Page Number: 6 nondiscrimination section			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: no $ limits on any benefits			
	Page Number: Exhibit A - Schedule of Benefits			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: no $ limits on any benefits			
	Page Number: Exhibit A - Schedule of Benefits			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: rescissions not listed as way for coverage to end, only non-payment of premiums or fraud			
	Page Number: p. 7 - When Coverage Ends			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Preventive covered at 100%			
	Page Number: p. 10 Definition of Preventive Services			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: includes dependent coverage to age 26			
	Page Number: P. 3 Dependent eligiblity			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: Process in place for both			
	Page Number: p. 31 describes appeals process			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

TENNESSEE

READIBILITY CERTIFICATE

COMPANY NAME: COMMUNITY HEALTH ALLIANCE MUTUAL INSURANCE COMPANY

As an Officer of Community Health Alliance Mutual Insurance Company, I hereby certify that the following forms achieve a Flesch score that meets or exceeds the requirements. Each form was scored in accordance with T.C.A. Sec. 56-7-1605.

Form Number	Flesch Score
ENT_100_EPO_14	40.5
ENT_100_POS_14	40.0
PTN_100_14	42.5

Judy Slagle, SVP and Chief Operating Officer

6/13/13
Date

ACTUARIAL MEMORANDUM

Community Health Alliance Mutual Insurance Company
Rates for Small Group Policies
Effective January 1, 2014

GENERAL INFORMATION

Company Legal Name: Community Health Alliance Mutual Insurance Company
State: Tennessee
HIOS Issuer ID: 66842
Market: Small Group
Effective Date: January 1, 2014

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INTRODUCTION

The purpose of this actuarial memorandum is to provide initial rates and supporting documentation for Community Health Alliance's (CHA) small group products.

CHA has engaged OptumInsight (Optum) to develop the premium rates for their new small group health policies, to test these rates for the expected medical loss ratios (MLR), and to file them with the Tennessee Insurance Division with an effective date of January 1, 2014. This will be CHA's first offering of small group plans.

PROPOSED RATE INCREASES

These plans, along with the individual group plans filed under separate cover, represent CHA's entrance into the Tennessee market. As such, they have no experience or current rates so proposed rate increases are not applicable.

EXPERIENCE PERIOD PREMIUM AND CLAIMS

As described above, CHA has no premium or claim experience. The rates were developed using external data sources. These sources and the adjustments made to them are discussed below.

BENEFIT CATEGORIES

As described above, we do not have claim experience. However, our rating model (discussed in greater detail below) has claims separated into the various components as follows. Note that these are basically consistent with the methods used in the URRT:

1. ***Inpatient Hospital*:** Includes facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

2. ***Outpatient Hospital*:** Includes non-capitated facility services for surgery, emergency room, urgent care, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.

3. ***Professional*:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory/radiology and surgery, and other professional services, other than hospital based professionals whose payments are included in facility fees.

4. ***Other Medical*:** Includes non-capitated ambulance, home health care, chiropractic, DME, prosthetics, supplies, vision exams, dental services, hearing aids, and other services.

5. ***Capitation*:** CHA does not anticipate having any capitated contracts in 2014

6. ***Prescription Drug*:** Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

PROJECTION FACTORS

Because we did not have experience to project, this is not applicable. The application of some of these adjustments to the manual pricing model is discussed in following sections.

CREDIBILITY MANUAL RATE DEVELOPMENT

Because we did not have experience to project, this is not applicable. The application of some of these adjustments to the manual pricing model is discussed in following sections.

1. SOURCE AND APPROPRIATENESS OF EXPERIENCE DATA USED

We used the Optum Comprehensive Pricing model to develop PMPM claims for an average 12 month policy period beginning 1/1/2014. The model has age, gender, and area claims relativities that allow it to calculate the PMPM claims separately for male and female members by age bracket, in different metropolitan statistical areas (MSAs) or in the non-MSA parts of states.

The data underlying the cost model come from the experience of commercial carriers during 2010-2011. There are 114 million member-months of exposures, primarily from large groups, with the rest from small groups and individuals. As such, the underlying data represent fairly closely the claims from an average commercially-insured, partially underwritten population by age bracket and gender.

2. ADJUSTMENTS MADE TO THE DATA

1. **Utilization:** The Optum model and underlying utilization are primarily based on large group experience. Adjustments were made to capture key underwriting differences between large group and small group plans. The most impactful difference is guarantee issue. Based on rate differences between small group and large group, we estimated that the impact of guarantee issue is an increase to utilization of roughly 10%.

2. **Unit Cost:** CHA will have two networks, a primary network with direct contracts and a secondary wrap network from a third-party vendor. Members will have access to both networks with no benefit differences based on point of service.

   Because CHA's direct network is still in development, we have relied on unit cost projections provided by CHA. These projections were based on a combination of discounts from signed provider contracts and anticipated discounts from contracts still under negotiation. The overall unit costs were developed by type of service (inpatient, outpatient, physician, and pharmacy). For each service type, we determined the discount from billed charges or percent of Medicare that would produce the appropriate cost levels in the model.

   For the secondary wrap network, we applied discounts provided by CHA to billed charges from the pricing model.

CREDIBILITY OF EXPERIENCE

Because CHA has no experience of their own, we have relied entirely on the base data in the pricing model with the adjustments mentioned above. The model includes over 114 million member months and we considered the manual rates based on the model to be fully credible.

PAID TO ALLOWED RATIO

As described above, each plan was priced independently using our pricing model. The model contains an underlying distribution of utilization and unit cost data by specific service type. The model then applies various cost sharing features (deductible, copay, coinsurance, etc.) to each service type. The allowed totals (on a statewide basis) are the same for all plans. The paid amount of each benefit is determined by reducing the allowed cost by the appropriate cost

sharing feature. The paid to allowed ratio is equal to the sum of all paid benefits divided by the sum of all allowed benefits.

Note that these values differ from the actuarial value calculator due to differences in the assumed claim distributions. The table below shows the calculated paid to allowed ratio for each plan.

TABLE 1
PAID TO ALLOWED RATIO BY PLAN

PLAN	RATIO
Bronze: CHA 6	49.4%
Silver: CHA HDP2	64.8%
Silver: CHA 5	59.6%
Silver: CHA 4	64.3%
Gold: CHA 3	74.0%
Gold : CHA 2	77.1%
Gold: CHA HDP 1	74.4%
Platinum: CHA 1	87.9%
Bronze: CHA Plus HDP 3	54.6%
Silver: CHA Plus 4	69.6%
Silver: CHA Plus 5	66.3%
Silver: CHA Plus 6	67.6%
Silver: CHA Plus HDP 2	68.5%
Gold: CHA Plus 1	84.2%
Gold: CHA Plus 2	81.2%
Gold: CHA Plus 3	80.6%
Gold : CHA Plus HDP 1	82.8%

RISK ADJUSTMENT AND REINSURANCE

No rate adjustments were made for the projected impact of risk adjustment. Because CHA has no block of business to consider at this point, we have assumed that they will ultimately end up with a block of approximately average risk and that they will not receive either a benefit or additional cost due to risk adjustment.

We have assumed that CHA will pay $5.25 PMPM on all their business in 2014. However, only individual plan will receive recoveries so no recoveries were assumed on small group plans.

NON-BENEFIT EXPENSES AND PROFIT RISK

CHA filed their 2014 budget as part of the CO-OP application process. As of today, they are using the same operating budget. This included a detailed budget and anticipated enrollment of

124,850 member months in small group plans. Based on these assumptions, we anticipate an administrative load of $58.51, or 18.1% of premium. They have also finalized their commission structure and we anticipate commissions of $21.99 PMPM or 6.8%. The administrative load is high relative to market standards. This is primarily due to lower first year enrollment, higher first year commissions, and start-up costs. We anticipate that administration will fall to more typical levels over time.

The pro forma financials which were filed with and approved by HHS included an allowance for budgeted losses. This will enable CHA to establish more competitive rates and grow market share, which is essential to their long-term success. The total approved losses for CHA in 2014 were $8.5 million. We have budgeted a loss of approximately $2.8 million, or $22.69 PMPM, with the remainder budgeted to CHA's individual business.

The rates include the following fees: $1 per member annually (or $0.08 PMPM) for risk adjustment, 3.5% for Exchange fees, and $5.25 PMPM for reinsurance premiums. We include an additional 2% load for premium tax. We do not expect 100% of CHA's small group business to be sold through the Exchange, so the 3.5% load could potentially be reduced. However, we have also not included the ACA insurer assessment as a separate adjustment. We believe that the expense for this tax can be recovered in whole or in part through the difference between the actual Exchange fee and the 3.5% built into the rates.

The table below shows the components of the average premium based on an average claim amount of $243.00 and the components above. We have assumed that all non-benefit expenses will be applied equally to all members as a percent of premium.

TABLE 2
COMPOSITE PREMIUM DEVELOPMENT

RATE COMPONENT	PMPM	PERCENT OF PREMIUM
Claims	$243.00	75.0%
Admin	$58.51	18.1%
Commission	$21.99	6.8%
Risk Adj	$0.08	0.0%
Reinsurance	$5.25	1.6%
Exchange Fee	$11.34	3.5%
Premium Tax	$6.48	2.0%
Margin	-$22.69	-7.0%
Premium	**$323.96**	

PROJECTED LOSS RATIO

The "traditional" (claims divided by premiums) expected MLR is 75.0%. We calculated MLRs for the proposed medical plans based on the projected claims and proposed rates using the method prescribed in the ACA for premium rebates, as follows:

1. ACA fees: See above. We estimate that the combined cost of ACA fees (exchange fees, federal reinsurance net recoveries, and risk adjustment) total $16.67 PMPM.

2. Anticipated taxes are $6.48

3. Based on the weighted average PMPM claims cost of $243.00 and premium of $323.96, the MLR (as used for rebate calculations) is then $243.00 divided by $300.81 [$323.96 - $16.67 - $6.48], or 80.8%.

4. With the credibility adjustments allowed by the ACA in determining a carrier's minimum MLR, and considering CHA's projected enrollment for 2014, we estimate that the minimum for CHA will not be higher than 78.0%.

INDEX RATE

CHA's rates were not developed using an index rate. Rates were developed using paid claim amounts from the Optum pricing model, with separate models for each plan design. In addition to separate plans, CHA will be using two different networks – a direct network and a secondary wrap network. The wrap network will be provided through a third-party vendor and has considerably higher unit costs than the direct network.

Further, the rates are based on the assumption that the network penetration (i.e., the percent of services provide in the direct network) will vary significantly by area depending on overall depth of network coverage. Because of these issues, the pricing model cannot be used directly to calculate the index rate.

For each rating area, we assumed that utilization would not vary depending on which network a patient uses. However, the unit cost varied significantly depending on the choice of network. With 100% direct network usage, the allowed claims total $358.87. With 0% direct network coverage, the allowed claims total $522.94.

In order to estimate the overall network penetration, it is necessary to consider the following:

1. The anticipated enrollment in each geographic rating area,

2. The assumed network penetration within each rating area,

3. The non-discounted unit cost relativity for each rating area relative to statewide average costs

Based on these calculations, we determined that the total costs on a statewide basis are equivalent to 92.4% network penetration. The total allowed cost was then calculated by blending the direct and wrap network unit costs based on these weightings. Because utilization assumptions did not vary between networks, no blending of utilization was necessary.

Based on these weightings, the allowed PMPM claim amount was $371.32. In 2014, all costs are based on the Essential Health Benefits. Hence, this value is CHA's index rate during the projection period.

AV METAL VALUES

The 17 small group plan designs being offered by CHA were defined using the actuarial value calculator developed by the Department of Health and Human Services (HHS). Several of the proposed plan designs contain plan features that could not be priced within the limitations of the calculator. In accordance with guidance from HHS, we are providing this certification to confirm that all the proposed plans fall within the +/- 2% margin for each of the metallic levels or +/-1% for CSR plans.

In order to evaluate the actuarial value impact of the benefit differences, we used our pricing model to develop expected claim costs that matched the calculator inputs exactly. We then developed expected claims for the actual plan benefits. We then compared the ratio of paid claims between plans and applied that factor to the actuarial value from the calculator.

The reasons that plans had to be adjusted from the actuarial value calculator fall into the following categories:

- The AV calculator makes no allowance for urgent care copays.
- The AV calculator does not allow cost sharing for lab and x-ray to vary by place of service (e.g., office vs. outpatient hospital)

Appendix II shows the specific benefit variations, the actuarial value according to the calculator, the net impact of benefit differences, and the final actuarial value for each of the proposed plans. Based on this analysis, all plans will fall within the appropriate metallic levels.

AV PRICING VALUES

The Silver 1 Plan has been used as the fixed reference plan for the AV pricing values. The table below illustrates the AV Pricing Value for each plan. Because administrative costs are allocated on a level basis across all plans (as a percent of premium), the differences in the AV pricing value are entirely attributable to differences in plan cost-sharing.

TABLE 3 COMPOSITE PREMIUM DEVELOPMENT	
PLAN	AV PRICING VALUE
Bronze: CHA 6	0.829
Silver: CHA HDP2	1.088
Silver: CHA 5	1.000
Silver: CHA 4	1.079
Gold: CHA 3	1.241
Gold : CHA 2	1.294
Gold: CHA HDP 1	1.248
Platinum: CHA 1	1.475
Bronze: CHA Plus HDP 3	0.916
Silver: CHA Plus 4	1.168
Silver: CHA Plus 5	1.113
Silver: CHA Plus 6	1.135
Silver: CHA Plus HDP 2	1.149
Gold: CHA Plus 1	1.413
Gold: CHA Plus 2	1.363
Gold: CHA Plus 3	1.352
Gold : CHA Plus HDP 1	1.390

MEMBERSHIP PROJECTIONS

This will be CHA's initial offering. As such, their membership projections are entirely built from the pro forma projections used in the CO-OP applications. Based on target market penetration assumptions and data from the HBSM, they anticipated 5,723 small group members in the Exchange and 5,627 small group members outside of the Exchange. Due to open enrollment, they projected that the majority of enrollment will be effective January 1 and the average member will be covered for 11 months. Note that the projected members were driven by market penetration assumptions, and slight differences between the members and member months are attributable to rounding.

Since CHA has no past experience to draw from, enrollment by plan is based on sales strategy and population characteristics. The table below shows the expected enrollment by metallic plan. Where more than one plan is offered for a given metallic level, it is assumed that enrollment will be equally divided.

TABLE 4 ASSUMED ENROLLMENT BY METALLIC LEVEL			
METALLIC PLAN	MEMBERS	PLANS	ENROLLMENT
Platinum	1.0%	1	1.0%
Gold	10.0%	7	1.4%
Silver	75.0%	7	10.7%
Bronze	14.0%	2	7.0%

TERMINATED PRODUCTS

There are no terminated products.

WARNING ALERT

The total projected premium differs by $425. This is a difference of only 0.001% and is attributable to rounding.

PLAN TYPE

All small group products offered in the Exchange are EPO plans. CHA will also offer POS plans exclusively off the Exchange.

RELIANCE ON OTHERS

I have relied on unit cost projections and area factor relativities provided by Michael Madalena in developing expected claim costs. I have not reviewed his projections, but the results seem reasonable in light of other information available to me.

ACTUARIAL CERTIFICATION

I, Earl L. Hoffman, am a member in good standing of the American Academy of Actuaries.

I certify that, to the best of my knowledge and judgment, the projected index rate is:

a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
b. Developed in compliance with the applicable Standard of Actuarial Practice,
c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
d. Neither excessive nor deficient.

I certify that the index rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

I certify that the percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

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SUMMARY OF EXHIBITS

Appendix I – Rate Tables

Appendix II – Actuarial Value Impact of Benefit Differences

Appendix III – Plan Descriptions

APPENDIX I
RATE TABLES

ALL RATES SHOWN ARE FOR NON-SMOKERS. RATES WILL BE MULTIPLIED BY THE APPROPRIATE AREA FACTOR AND SMOKING ADJUSTMENT.

Age	Bronze CHA 6	Silver CHA HDP 2	Silver CHA 5	Silver CHA 4	Gold CHA 3	Gold CHA 2	Gold CHA HDP 1	Platinum CHA 1
0 – 20	$118.73	$155.70	$143.15	$154.50	$177.69	$185.18	$178.64	$211.20
21	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
22	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
23	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
24	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
25	$187.73	$246.17	$226.34	$244.28	$280.95	$292.79	$282.45	$333.93
26	$191.46	$251.07	$230.84	$249.14	$286.54	$298.63	$288.08	$340.58
27	$195.95	$256.96	$236.26	$254.98	$293.26	$305.63	$294.83	$348.56
28	$203.24	$266.52	$245.05	$264.47	$304.17	$317.00	$305.80	$361.53
29	$209.23	$274.37	$252.26	$272.26	$313.13	$326.33	$314.80	$372.18
30	$212.22	$278.29	$255.87	$276.15	$317.60	$331.00	$319.30	$377.50
31	$216.71	$284.17	$261.28	$281.99	$324.32	$338.00	$326.05	$385.48
32	$221.19	$290.06	$266.69	$287.83	$331.04	$345.00	$332.81	$393.46
33	$224.00	$293.74	$270.07	$291.48	$335.23	$349.37	$337.03	$398.45
34	$226.99	$297.66	$273.68	$295.37	$339.71	$354.04	$341.53	$403.77
35	$228.49	$299.62	$275.48	$297.32	$341.95	$356.37	$343.78	$406.44
36	$229.98	$301.58	$277.28	$299.26	$344.19	$358.70	$346.03	$409.10
37	$231.48	$303.54	$279.09	$301.21	$346.43	$361.03	$348.28	$411.76
38	$232.97	$305.51	$280.89	$303.15	$348.67	$363.37	$350.53	$414.42
39	$235.97	$309.43	$284.50	$307.05	$353.14	$368.03	$355.03	$419.74
40	$238.96	$313.35	$288.11	$310.94	$357.62	$372.70	$359.53	$425.06
41	$243.44	$319.24	$293.52	$316.78	$364.34	$379.70	$366.28	$433.04
42	$247.75	$324.88	$298.70	$322.38	$370.77	$386.41	$372.75	$440.69
43	$253.73	$332.72	$305.91	$330.16	$379.73	$395.74	$381.76	$451.34
44	$261.21	$342.53	$314.93	$339.89	$390.92	$407.40	$393.01	$464.64
45	$270.00	$354.05	$325.53	$351.33	$404.07	$421.11	$406.23	$480.27
46	$280.47	$367.78	$338.15	$364.95	$419.74	$437.44	$421.99	$498.90
47	$292.25	$383.23	$352.35	$380.28	$437.37	$455.81	$439.71	$519.85
48	$305.71	$400.88	$368.59	$397.80	$457.52	$476.81	$459.96	$543.80
49	$318.98	$418.29	$384.59	$415.07	$477.39	$497.52	$479.94	$567.41
50	$333.94	$437.91	$402.63	$434.54	$499.77	$520.85	$502.44	$594.02
51	$348.71	$457.28	$420.44	$453.76	$521.88	$543.89	$524.67	$620.30
52	$364.98	$478.61	$440.05	$474.93	$546.22	$569.26	$549.14	$649.23
53	$381.43	$500.19	$459.89	$496.34	$570.85	$594.92	$573.90	$678.50
54	$399.20	$523.48	$481.30	$519.45	$597.43	$622.62	$600.63	$710.10
55	$416.96	$546.77	$502.72	$542.56	$624.02	$650.33	$627.35	$741.70
56	$436.22	$572.03	$525.94	$567.62	$652.84	$680.37	$656.33	$775.95
57	$455.66	$597.53	$549.38	$592.93	$681.94	$710.70	$685.59	$810.54
58	$476.42	$624.74	$574.41	$619.93	$713.00	$743.07	$716.81	$847.46
59	$486.70	$638.23	$586.81	$633.32	$728.39	$759.11	$732.29	$865.75
60	$507.46	$665.44	$611.83	$660.32	$759.45	$791.48	$763.51	$902.67
61	$525.41	$688.98	$633.47	$683.68	$786.32	$819.47	$790.52	$934.60
62	$537.19	$704.43	$647.67	$699.01	$803.95	$837.85	$808.24	$955.56
63	$551.96	$723.80	$665.48	$718.23	$826.05	$860.88	$830.47	$981.83
64+	$560.93	$735.57	$676.30	$729.91	$839.48	$874.88	$843.97	$997.80

Age	Bronze CHA Plus HDP 3	Silver CHA Plus 4	Silver CHA Plus 5	Silver CHA Plus 6	Silver CHA Plus HDP 2	Gold CHA Plus 1	Gold CHA Plus 2	Gold CHA Plus 3	Gold CHA Plus HDP 1
0 – 20	$131.17	$167.20	$159.35	$162.52	$164.52	$202.24	$195.18	$193.57	$198.95
21	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
22	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
23	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
24	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
25	$207.40	$264.36	$251.94	$256.97	$260.12	$319.77	$308.60	$306.05	$314.57
26	$211.53	$269.63	$256.96	$262.09	$265.30	$326.14	$314.75	$312.15	$320.83
27	$216.49	$275.94	$262.98	$268.23	$271.52	$333.78	$322.13	$319.46	$328.35
28	$224.54	$286.21	$272.77	$278.21	$281.62	$346.20	$334.12	$331.35	$340.57
29	$231.15	$294.64	$280.80	$286.40	$289.92	$356.39	$343.95	$341.11	$350.60
30	$234.46	$298.85	$284.82	$290.50	$294.06	$361.49	$348.87	$345.98	$355.61
31	$239.42	$305.17	$290.84	$296.64	$300.28	$369.13	$356.25	$353.30	$363.13
32	$244.37	$311.49	$296.86	$302.78	$306.50	$376.78	$363.62	$360.62	$370.65
33	$247.47	$315.44	$300.63	$306.62	$310.38	$381.55	$368.23	$365.19	$375.35
34	$250.78	$319.65	$304.64	$310.72	$314.53	$386.65	$373.15	$370.07	$380.36
35	$252.43	$321.76	$306.65	$312.76	$316.60	$389.20	$375.61	$372.50	$382.87
36	$254.08	$323.87	$308.66	$314.81	$318.67	$391.75	$378.07	$374.94	$385.37
37	$255.73	$325.97	$310.66	$316.86	$320.75	$394.29	$380.53	$377.38	$387.88
38	$257.39	$328.08	$312.67	$318.91	$322.82	$396.84	$382.99	$379.82	$390.39
39	$260.69	$332.29	$316.69	$323.00	$326.96	$401.94	$387.91	$384.70	$395.40
40	$264.00	$336.51	$320.70	$327.10	$331.11	$407.03	$392.82	$389.57	$400.41
41	$268.95	$342.82	$326.72	$333.24	$337.33	$414.68	$400.20	$396.89	$407.93
42	$273.71	$348.88	$332.49	$339.13	$343.29	$422.00	$407.27	$403.90	$415.14
43	$280.32	$357.31	$340.52	$347.32	$351.58	$432.19	$417.11	$413.66	$425.17
44	$288.58	$367.84	$350.56	$357.55	$361.94	$444.93	$429.40	$425.85	$437.70
45	$298.29	$380.21	$362.36	$369.58	$374.12	$459.90	$443.85	$440.18	$452.42
46	$309.86	$394.96	$376.41	$383.92	$388.63	$477.74	$461.06	$457.25	$469.97
47	$322.87	$411.55	$392.22	$400.04	$404.95	$497.80	$480.43	$476.45	$489.71
48	$337.74	$430.51	$410.29	$418.47	$423.60	$520.73	$502.56	$498.40	$512.27
49	$352.41	$449.20	$428.10	$436.64	$442.00	$543.35	$524.38	$520.04	$534.51
50	$368.93	$470.26	$448.18	$457.12	$462.72	$568.83	$548.97	$544.43	$559.58
51	$385.25	$491.07	$468.00	$477.34	$483.19	$593.99	$573.25	$568.51	$584.33
52	$403.23	$513.97	$489.83	$499.60	$505.73	$621.70	$599.99	$595.03	$611.59
53	$421.40	$537.14	$511.92	$522.13	$528.53	$649.72	$627.04	$621.86	$639.16
54	$441.03	$562.16	$535.76	$546.44	$553.14	$679.98	$656.24	$650.81	$668.92
55	$460.65	$587.17	$559.59	$570.76	$577.76	$710.24	$685.44	$679.77	$698.69
56	$481.93	$614.29	$585.44	$597.12	$604.44	$743.04	$717.10	$711.17	$730.96
57	$503.41	$641.68	$611.54	$623.74	$631.39	$776.17	$749.07	$742.87	$763.54
58	$526.34	$670.90	$639.39	$652.15	$660.15	$811.52	$783.19	$776.71	$798.32
59	$537.70	$685.39	$653.20	$666.22	$674.40	$829.04	$800.09	$793.48	$815.55
60	$560.63	$714.61	$681.05	$694.63	$703.15	$864.39	$834.21	$827.31	$850.33
61	$580.46	$739.89	$705.14	$719.20	$728.03	$894.96	$863.72	$856.58	$880.41
62	$593.48	$756.48	$720.95	$735.33	$744.35	$915.03	$883.09	$875.78	$900.15
63	$609.80	$777.28	$740.77	$755.55	$764.82	$940.19	$907.37	$899.86	$924.90
64+	$619.71	$789.92	$752.82	$767.83	$777.25	$955.48	$922.12	$914.49	$939.94

GEOGRAPHIC AREA FACTORS

RATING AREA	AREA FACTOR
East	1.530
Greater Knoxville	0.996
Greater Chattanooga	1.451
Greater Nashville	1.009
West	0.998
Greater Memphis	1.001
East Central	1.407
West Central	0.986

SMOKER STATUS

SMOKER STATUS	AREA FACTOR
Non-Smoker	1.00
Smoker	1.25

APPENDIX II
ACTUARIAL VALUE IMPACT OF BENEFIT DIFFERENCES

PLANS TO BE OFFERED ON AND OFF THE EXCHANGE

	BENEFIT DIFFERENCES				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Platinum: CHA 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	88.6%	0.997	88.3%
Gold: CHA 3 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.5%	0.990	78.7%
Gold: CHA 2 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	82.5%	0.992	81.9%
Gold: CHA HDP 1 EPO	No Differences		78.2%	1.000	78.2%
Silver: CHA 5 EPO	No Differences		69.1%	1.000	69.1%
Silver: CHA 4 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $55 Copay	72.5%	0.984	71.4%
Silver: CHA HDP 2 EPO	No Differences		71.0%	1.000	71.0%
Bronze: CHA 6 EPO	No Differences		62.0%	1.000	62.0%

PLANS TO BE OFFERED OFF THE EXCHANGE ONLY

	BENEFIT DIFFERENCES (APPLIES TO IN-NETWORK BENEFITS ONLY)				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Gold: CHA Plus 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	81.3%	0.990	80.5%
Gold: CHA Plus 2	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.8%	0.989	78.9%
Gold: CHA Plus 3	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.1%	0.989	78.2%
Gold: CHA Plus HDP 1	No Differences		78.8%	1.000	78.8%
Silver: CHA Plus 4	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $50 Copay	72.7%	0.984	71.6%

	Benefit Differences (Applies to In-Network Benefits Only)				
Plan	**Calculator Inputs**	**Proposed Benefit**	**Actuarial Value (Calculator)**	**Impact of Benefit Difference**	**Final Actuarial Value**
Silver: CHA Plus 5	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $65 Copay	71.7%	0.983	70.5%
Silver: CHA Plus 6	No Differences		69.2%	1.000	69.2%
Silver: CHA Plus HDP 2	No Differences		68.9%	1.000	68.9%
Bronze: CHA Plus HDP 3	No Differences		61.0%	1.000	61.0%

APPENDIX III
PLAN DESCRIPTIONS

Exchange/Off Exchange Plans		Platinum CHA 1 EPO	Gold CHA 2 EPO	Gold CHA 3 EPO	Gold HDP 1 EPO	Silver CHA 5 EPO	Silver CHA 4 EPO	Silver HDP 2 EPO	Bronze CHA 6 EPO
Deductible	Single	$250	$500	$1,250	$1,500	$2,000	$2,000	$1,750	$4,000
	Family	$500	$1,000	$2,500	$3,000	$4,000	$4,000	$3,500	$8,000
Out of Pocket Maximum	Single	$2,250	$4,500	$4,500	$3,000	$6,400	$6,400	$5,250	$6,400
	Family	$4,500	$9,000	$9,000	$6,000	$12,800	$12,800	$10,500	$12,800
Coinsurance		100%	90%	80%	80%	60%	70%	80%	60%
Office/Free Standing Clinic	PCP	$15	$20	$20	Ded/Coins	$35	$25	Ded/Coins	$30
	Specialist	$40	$50	$50	Ded/Coins	Ded/Coins	$55	Ded/Coins	Ded/Coins
	Lab	100%	100%	100%	Ded/Coins	Ded/Coins	100%	Ded/Coins	Ded/Coins
	Xray	100%	100%	100%	Ded/Coins	Ded/Coins	100%	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		Ded/Coins	$250	$100+Coins	$100+Coins	Ded/Coins	$150+Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	$50	$50	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
PT/OT/ST		Ded/Coins	Ded/Coins	Coins	Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$10	$10	$10	Ded/Coins	$10	$10	Ded/Coins	Ded/Coins
	Preferred Brand	$25	$30	$30	Ded/Coins	$40	$35	Ded/Coins	Ded/Coins
	Non-Pref Brand	$50	$60	$60	Ded/Coins	$75	$65	Ded/Coins	Ded/Coins
	Specialty	Coins	Coins	Coins	Ded/Coins	Coins	Coins	Ded/Coins	Ded/Coins
Non-Network	Emergency Care Only (Same as In-Network)								

Off Exchange Only Plans		Gold: CHA Plus 1		Gold: CHA Plus 2		Gold: CHA Plus 3	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$1,000	$2,000	$1,000	$2,000	$1,000	$2,000
	Family	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Out of Pocket Maximum	Single	$4,000	$8,000	$4,000	$8,000	$4,500	$9,000
	Family	$8,000	$16,000	$8,000	$16,000	$9,000	$18,000
Coinsurance		80%	60%	70%	50%	70%	50%
Office/Free Standing Clinic	PCP	$20	Ded/Coins	$20	Ded/Coins	$20	Ded/Coins
	Specialist	$45	Ded/Coins	$50	Ded/Coins	$50	Ded/Coins
	Lab	100%	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
	Xray	100%	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		$100+Coins		$100+Coins		$100+Coins	
Urgent Care		$50	$50	$50	$50	$50	$50
PT/OT/ST		Coins	Coins	Coins	Coins	Coins	Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$10	Not Covered	$10	Not Covered	$10	Not Covered
	Preferred Brand	$25	Not Covered	$30	Not Covered	$30	Not Covered
	Non-Pref Brand	$55	Not Covered	$60	Not Covered	$60	Not Covered
	Specialty	Coins	Not Covered	Coins	Not Covered	Coins	Not Covered

Off Exchange Only Plans		Gold: CHA Plus HDP 1		Silver: CHA Plus 4		Silver: CHA Plus 5	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
	Family	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000
Out of Pocket Maximum	Single	$2,000	$6,000	$6,400	$12,800	$6,400	$12,800
	Family	$4,000	$12,000	$12,800	$25,600	$12,800	$25,600
	Coinsurance	100%	70%	70%	50%	60%	40%
Office/Free Standing Clinic	PCP	Ded/Coins	Ded/Coins	$25	Ded/Coins	$35	Ded/Coins
	Specialist	Ded/Coins	Ded/Coins	$50	Ded/Coins	$65	Ded/Coins
	Lab	Ded/Coins	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
	Xray	Ded/Coins	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Emergency Room	Ded/Coins		$150 + Coins		$150 + Coins	
	Urgent Care	Ded/Coins	Ded/Coins	$50	$50	$65	$65
	PT/OT/ST	Ded/Coins	Ded/Coins	$50	$50	$65	Ded/Coins
	All Other	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	Ded/Coins	Not Covered	$10	Not Covered	$10	Not Covered
	Preferred Brand	Ded/Coins	Not Covered	$40	Not Covered	$40	Not Covered
	Non-Pref Brand	Ded/Coins	Not Covered	$75	Not Covered	$75	Not Covered
	Specialty	Ded/Coins	Not Covered	Coins	Not Covered	Coins	Not Covered

Off Exchange Only Plans		Silver CHA Plus 6		Silver CHA Plus HDP 2		Bronze CHA Plus HDP 3	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$2,000	$4,000	$2,000	$4,000	$5,500	$8,000
	Family	$4,000	$8,000	$4,000	$8,000	$11,000	$16,000
Out of Pocket Maximum	Single	$6,400	$12,800	$6,000	$12,000	$5,500	$12,000
	Family	$12,800	$25,600	$12,000	$24,000	$11,000	$24,000
	Coinsurance	70%	50%	80%	60%	100%	70%
Office/Free Standing Clinic	PCP	$35	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Specialist	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Xray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Emergency Room	Ded/Coins		Ded/Coins		Ded/Coins	
	Urgent Care	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	PT/OT/ST	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	All Other	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$15	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Preferred Brand	$45	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Non-Pref Brand	$75	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Specialty	Coins	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered

ACTUARIAL MEMORANDUM

Community Health Alliance Mutual Insurance Company
Rates for Small Group Policies
Effective January 1, 2014

INTRODUCTION

The purpose of this actuarial memorandum is to provide initial rates and supporting documentation for Community Health Alliance's (CHA) small group products.

CHA has engaged OptumInsight (Optum) to develop the premium rates for its new small group health policies, to test these rates for the expected medical loss ratios (MLR), and to file them with the Tennessee Insurance Division with an effective date of January 1, 2014. This will be CHA's first offering of small plans.

BENEFIT PLANS AND RATE STRUCTURE

CHA will be offering 17 small group plans at the Platinum, Gold, Silver, and Bronze metallic levels, including 8 plans to be sold both on the exchange and off. The remaining nine plans will only be offered off of the exchange. Appendix III provides high level descriptions of the key benefit features of these plans.

The rates for each of these plans are structured as follows:

- Age brackets and factors corresponding to the HHS Standard Age Curve;
- Eight rating areas, as defined by regulation: East, Greater Knoxville, Greater Chattanooga, Greater Nashville, West, Greater Memphis, East Central, and West Central. CHA will not be marketing to employers in the East, Greater Chattanooga, or East Central rating areas in 2014. Rates for these areas are being filed with the expectation that some employers in the other rating areas may have employees residing in these areas;
- Rating tiers for smoker (1.25 factor) vs. non-smoker (1.00 factor).

RATE DEVELOPMENT ASSUMPTIONS

OptumInsight Cost Model

We used the Optum Comprehensive Pricing model to develop PMPM claims for an average 12 month policy period beginning 1/1/2014. The model has age, gender, and area claims relativities that allow it to calculate the PMPM claims separately for male and female members by age bracket, in different metropolitan statistical areas (MSAs) or in the non-MSA parts of states.

The data underlying the cost model come from the experience of commercial carriers during 2010-2011. There are 114 million member-months of exposures, primarily from large groups, with the rest from small groups and individuals. As such, the underlying data represent fairly closely the claims from an average commercially-insured, partially underwritten population by age bracket and gender.

Morbidity (Claim Costs) Assumptions

We made the following adjustments to the model claims costs:

1. **Age and gender:** The Optum model has factors, developed from the claims by age and gender in the database, that adjust the PMPM allowed costs for these factors. The model makes these adjustments for each service line (inpatient, outpatient, physician, prescription drugs).

2. **Location:** Initial claim costs were developed at a statewide level for Tennessee. To develop relativities for each rating area, we matched each county to its corresponding MSA (or non-MSA area) and identified each county's population based on 2010 national census data. Based on this information, we developed a distribution of population, by MSA, within each rating area. We then modeled a 100% coverage plan ($0 deductible, 100% coinsurance) for each rating area, as well as on a statewide basis. The ratio of each rating area's projected claim cost to the statewide total (on a PMPM basis) was used as the rating area relativity.

3. **Provider contracting and network utilization:** CHA will have two networks, a primary network with direct contracts and a secondary wrap network from a third-party vendor. Members will have access to both networks with no benefit differences based on point of service. CHA's primary network is currently under development, so we have relied entirely on CHA to estimate what the ultimate costs and/or discounts will be.

   We developed assumptions about direct vs. wrap network penetration (i.e., the percent of services by network) for each rating area. These assumptions were based on input from provider contracting and considered overall usage levels of providers in the direct network, as well as the number of contracted providers in the direct vs. wrap networks. The penetration assumptions, by rating area, are summarized in the table below.

TABLE 1 NETWORK UTILIZATION BY RATING AREA		
RATING AREA	DIRECT NETWORK PENETRATION	WRAP NETWORK PENETRATION
East	0%	100%
Greater Knoxville	90%	10%
Greater Chattanooga	0%	100%
Greater Nashville	90%	10%
West	80%	20%
Greater Memphis	100%	0%
East Central	0%	100%
West Central	90%	10%

The plans offered both and off the Exchange are all exclusive provider plans, so we assumed no out-of-network usage. Off the Exchange, CHA will offer POS plans with non-network benefits. We have assumed 10% non-network utilization on these plans.

4. **Utilization:** The Optum model and underlying utilization are primarily based on large group experience. These utilization assumptions were increased by 10% in order to project the additional claim costs anticipated due to guarantee issue in the small group population.

5. **Unit Cost:** Because CHA's network is still in development, we have relied on unit cost projections provided by CHA. These projections were based on a combination of discounts from signed provider contracts and anticipated discounts from contracts still under negotiation. The overall unit costs were developed my type of service (inpatient, outpatient, physician, and pharmacy). For each service type, we determined the discount from billed charges or percent of Medicare that would produce the appropriate cost levels in the model.

   For the secondary wrap network, we applied discounts to billed charges provided by CHA. We assumed 0% discount for non-network benefits.

Policy Lapse Assumption

We have not made explicit assumptions about policy lapses. Our projections were based on net projected membership throughout the year.

Member Distribution Assumption

The assumed distribution of employees by issue age and family composition is shown in the table below. This distribution is based on Optum's Health Benefit Simulation Model (HBSM), which was developed to project the movement of individuals between various levels of coverage

(uninsured, individual exchange, employer coverage, etc.) due to the implementation of the Accountable Care Act (ACA).

The HBSM projects movement between levels by state and by county based on a variety of parameters, including anticipated rate changes due to the ACA, employer earnings, and Medicaid expansion. Based on the age and tier mix of the population below, the anticipated average contract size is 1.999.

TABLE 2
ASSUMED MEMBER DISTRIBUTION

AGES	MEMBERS
< 20	27.1%
20 - 24	8.9%
25 - 29	8.2%
30 - 34	8.4%
35 - 39	8.4%
40 - 44	9.0%
45 - 49	9.0%
50 - 54	8.2%
55 - 59	7.6%
60 - 64	3.9%
65+	1.3%

Interest, Administrative Expense, Commission, and ACA Fee Assumptions

The following are the expense, tax, fee, and commission assumptions:

- Premium tax: 2%

  ACA-related fees: The ACA temporary reinsurance fee payable in 2014 is $5.25 PMPM. We estimate that the ACA reinsurer fee will be approximately 3.5% of premium, starting in 2014. In reality, this load will likely be smaller due to the expectation of non-Exchange premium. Since it is not clear how much of CC's enrollment will come from the Exchange, we have allotted the full 3.5% Exchange fee but have not included an additional charge for the ACA insurer tax.

  We have also included an additional $1 PMPY (or approximately $0.08 PMPM) for the federal risk adjustment program. We have assumed that HCA will have average risk overall and have not assumed any gains or losses in our rate setting.

- Administrative Expense: $58.51 PMPM; this amount is higher than average for small group plans and is largely driven by first year start-up costs and lower first year enrollment. We anticipate that this value will decrease steadily over time as HCA grows their market share.

- CHA will work support three distribution channels similar to Individual products to sell and retain Small Group business. However, unlike Individual products, in 2014 CHA expects all contracts sold to come through the broker channel. This is based on current market dynamics responses received from employers. The three channels are as follows:

  - Direct sales through the Navigator
  - Direct sales through the Market Partner (described below)
  - Contracts sold through a broker

  CHA will use a vendor called a Marketing Partner will perform traditional front office duties on behalf of the co-ops. CHA will pay a combination of commission, fee override and fees to the Marketing Partner depending on whether the service is a direct sale, or support of a sale through a broker, or a one-time function such as a new broker certification.

  Commissions are paid as flat dollar amounts per member per month. These commissions vary depending upon whether the business is placed through a broker, direct through the Marketing Partner, from the Exchange/Navigator (in which case, there is no commission). Based on information from CHA, we assume 100% of new business will come via brokers inside and outside the Exchange, and 85% of Small Group contracts will be sold outside the SHOP Exchange.

  For contracts sold through a broker, the broker will receive $25.00 for each subscriber and $10.00 per each dependent. CHA did not vary the commission by the size of the group. The Marketing Partner will receive a 10% override for contracts sold through the Exchange and 20% override for contracts sold outside the Exchange. The marketing Partner will receive the commission if the contract is sold directly through the Marketing Partner with no broker support. The Marketing Partner is paid a one fee of $20.00 for each broker appointment, and $4.50 per broker a month for transactional cost of paying broker commissions. No commission or overrides are paid for business sold directly through the Exchange or through a Navigator. The weighted average of the commission and overrides through the three changes and segments is $21.99 PMPM.

- Margin/Provision for Contingencies: CHA's solvency requirements during their first five years of operation are largely being funded by the federal CO-OP program. Because enrollment growth and market share are critical to the CO-OP's success, the business plan filed with and approved by CMS projected budgeted operating losses in 2014 and 2015. In aggregate, these losses were projected to total approximately $8.5 million in 2014 with the resulting shortfall in surplus being funded through federal solvency loans.

Based on projected enrollment, we have budgeted a loss of $2.8 million, or $22.69 PMPM, for CHA's small group plans in the first policy year. The remaining losses have been allocated to CHA's individual plans. This results in a margin of -7.0% on CHA's small group plans.

Because we do not consider investment income material to these products, we have made no interest assumptions.

RATE DEVELOPMENT PROCESS

The following is a general description of the rate development method:

1. We first ran each plan design through our cost model to derive statewide claims by age bracket using the assumptions described above. These claim costs were based on the assumed direct network discounts/percent of Medicare. We then ran each of the plan designs through the cost model using the assumed discounts for the secondary wrap network. This gave us two expected statewide claim amounts for each plan design – one based on the primary network and one based on the secondary wrap network.

   For each plan, the plan design factor is calculated as the ratio of the PMPM claim amount for the plan to the composite PMPM amount for each plan. The plan design factors for each plan are shown in Appendix I.

2. Statewide expected claims for each plan design were combined into a single statewide rate for both the direct and wrap networks. The assumed distribution of plans by metallic level is shown in the table below. Since CHA is offering multiple plans at each metallic level, it was assumed that enrollment would be evenly distributed across each plan at a given level.

TABLE 3
ASSUMED ENROLLMENT BY METALLIC LEVEL

METALLIC PLAN	ENROLLMENT
Platinum	1.0%
Gold	10.0%
Silver	75.0%
Bronze	14.0%

   Based on the assumptions described above, the expected statewide claims for the direct network were $233.94 PMPM. For the wrap network, the expected claims were $353.24 PMPM.

3. For each rating area, as well as statewide, we ran the weighted population through the cost model for a 100% plan (no deductible, 100% coinsurance). We estimated the

geographic claim adjustments based on the ratio of PMPM claims in each rating area to the statewide claim amount. The table below shows the resulting relativities.

TABLE 4
AREA CLAIMS COST FACTORS

LOCATION	FACTOR
East	1.052
Greater Knoxville	0.984
Greater Chattanooga	0.998
Greater Nashville	0.997
West	0.941
Greater Memphis	1.040
East Central	0.968
West Central	0.975

4. For each plan, the statewide direct network claim costs were blended with the statewide wrap network claim costs based on each combination of weights shown in Table 1. For each rating area, the cost factor from Table 4 was multiplied by the corresponding blended claim cost to calculate a region-specific blended claim amount.

5. Based on HCA's sales strategy, the blended claim amounts from Step 4 were weighted based on the projected enrollment distribution by rating area. The final area factor for each rating area was calculated as the ratio of the expected claims to the estimated statewide claim cost. The table below shows the projected distribution by rating area, expected direct network penetration for each area, expected claim amounts (blended between networks), the resulting area factors, and the statewide composite claim amount.

TABLE 5
AREA FACTOR DEVELOPMENT

RATING AREA	ENROLLMENT	DIRECT NETWORK WEIGHT	CLAIMS	AREA FACTOR
East	0%	0%	$371.71	1.53
Greater Knoxville	24%	90%	$242.01	1.00
Greater Chattanooga	0%	0%	$352.51	1.45
Greater Nashville	20%	90%	$245.06	1.01
West	8%	80%	$242.50	1.00
Greater Memphis	40%	100%	$243.33	1.00
East Central	0%	0%	$341.85	1.41
West Central	8%	90%	$239.60	0.99
Statewide	**100%**		**$243.00**	

6. The statewide composite premium rate was calculated as the sum of expected claims, administrative costs, commissions, ACA fees, premium tax, and expected margin (or loss, in this case). The table below shows the development of a composite premium rate of $323.96 PMPM.

TABLE 6
COMPOSITE PREMIUM DEVELOPMENT

RATE COMPONENT	PMPM	PERCENT OF PREMIUM
Claims	$243.00	75.0%
Admin	$58.51	18.1%
Commission	$21.99	6.8%
Risk Adj	$0.08	0.0%
Reinsurance	$5.25	1.6%
Exchange Fee	$11.34	3.5%
Premium Tax	$6.48	2.0%
Margin	-$22.69	-7.0%
Premium	**$323.96**	

7. Based on the age factors from the HHS Standard Age Curve, the relativities between claims for each plan design, and the expected distribution of age and plan enrollment, rates were created for each plan design and age group based on the composite premium of $323.96 with a target "traditional" loss ratio (claims divided by premium) of 75.0%.

8. For each area, the premium rate for each age and plan is equal to the composite premium rate from Step 7 multiplied by the area factor from Step 5 and the appropriate smoker status adjustment.

The final rating factors are shown in Appendix I.

CALCULATION OF ANTICIPATED MEDICAL LOSS RATIO (MLR)

We calculated MLRs for the proposed medical plans based on the projected claims and proposed rates using the method prescribed in the ACA for premium rebates, as follows:

1. ACA fees: See above. We estimate that the combined cost of ACA fees (exchange fees, federal reinsurance net recoveries, and risk adjustment) total $16.67 PMPM.

2. Taxes are $6.48 PMPM.

3. Based on the weighted average PMPM claims cost of $243.00 and premium of $323.96, the MLR (as used for rebate calculations) is then $243.00 divided by $300.81 [$323.96 - $16.67- $6.48], or 80.8%.

4. With the credibility adjustments allowed by the ACA in determining a carrier's minimum MLR, and considering CHA's projected enrollment for 2014, we estimate that the minimum for CHA will not be higher than 78.0%.

5. The "traditional" (claims divided by premiums) expected MLR is 75.0%.

DEVIATIONS FROM ACTUARIAL VALUE CALCULATOR

The 17 small group plan designs being offered by CHA were defined using the actuarial value calculator developed by the Department of Health and Human Services (HHS). Several of the proposed plan designs contain plan features that could not be priced within the limitations of the calculator. In accordance with guidance from HHS, we are providing this certification to confirm that all the proposed plans fall within the +/- 2% margin for each of the metallic levels.

In order to evaluate the actuarial value impact of the benefit differences, we used our pricing model to develop expected claim costs that matched the calculator inputs exactly. We then developed expected claims for the actual plan benefits. We then compared the ratio of paid claims between plans and applied that factor to the actuarial value from the calculator.

Appendix II shows the specific benefit variations, the actuarial value according to the calculator, the net impact of benefit differences, and the final actuarial value for each of the proposed plans. Based on this analysis, all plans will fall within the appropriate metallic levels.

ACTUARIAL CERTIFICATION

I am a member in good standing of the American Academy of Actuaries. I certify that, to the best of my knowledge and judgment, this entire rate filing is in compliance with the applicable laws of the State of Tennessee and with the rules of the Tennessee Insurance Division and that the benefits are reasonable in relation to the premiums.

Earl L. Hoffman, FSA, MAAA
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SUMMARY OF EXHIBITS

Appendix I – Rating Factors

Appendix II – Actuarial Value Impact of Benefit Differences

Appendix III – Plan Descriptions

APPENDIX I
SMALL GROUP RATING FACTORS

Exchange and Non-Exchange Plans

Age	Bronze CHA 6	Silver CHA HDP 2	Silver CHA 5	Silver CHA 4	Gold CHA 3	Gold CHA 2	Gold CHA HDP 1	Platinum CHA 1
0 – 20	$118.73	$155.70	$143.15	$154.50	$177.69	$185.18	$178.64	$211.20
21	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
22	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
23	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
24	$186.98	$245.19	$225.43	$243.30	$279.83	$291.63	$281.32	$332.60
25	$187.73	$246.17	$226.34	$244.28	$280.95	$292.79	$282.45	$333.93
26	$191.46	$251.07	$230.84	$249.14	$286.54	$298.63	$288.08	$340.58
27	$195.95	$256.96	$236.26	$254.98	$293.26	$305.63	$294.83	$348.56
28	$203.24	$266.52	$245.05	$264.47	$304.17	$317.00	$305.80	$361.53
29	$209.23	$274.37	$252.26	$272.26	$313.13	$326.33	$314.80	$372.18
30	$212.22	$278.29	$255.87	$276.15	$317.60	$331.00	$319.30	$377.50
31	$216.71	$284.17	$261.28	$281.99	$324.32	$338.00	$326.05	$385.48
32	$221.19	$290.06	$266.69	$287.83	$331.04	$345.00	$332.81	$393.46
33	$224.00	$293.74	$270.07	$291.48	$335.23	$349.37	$337.03	$398.45
34	$226.99	$297.66	$273.68	$295.37	$339.71	$354.04	$341.53	$403.77
35	$228.49	$299.62	$275.48	$297.32	$341.95	$356.37	$343.78	$406.44
36	$229.98	$301.58	$277.28	$299.26	$344.19	$358.70	$346.03	$409.10
37	$231.48	$303.54	$279.09	$301.21	$346.43	$361.03	$348.28	$411.76
38	$232.97	$305.51	$280.89	$303.15	$348.67	$363.37	$350.53	$414.42
39	$235.97	$309.43	$284.50	$307.05	$353.14	$368.03	$355.03	$419.74
40	$238.96	$313.35	$288.11	$310.94	$357.62	$372.70	$359.53	$425.06
41	$243.44	$319.24	$293.52	$316.78	$364.34	$379.70	$366.28	$433.04
42	$247.75	$324.88	$298.70	$322.38	$370.77	$386.41	$372.75	$440.69
43	$253.73	$332.72	$305.91	$330.16	$379.73	$395.74	$381.76	$451.34
44	$261.21	$342.53	$314.93	$339.89	$390.92	$407.40	$393.01	$464.64
45	$270.00	$354.05	$325.53	$351.33	$404.07	$421.11	$406.23	$480.27
46	$280.47	$367.78	$338.15	$364.95	$419.74	$437.44	$421.99	$498.90
47	$292.25	$383.23	$352.35	$380.28	$437.37	$455.81	$439.71	$519.85
48	$305.71	$400.88	$368.59	$397.80	$457.52	$476.81	$459.96	$543.80
49	$318.98	$418.29	$384.59	$415.07	$477.39	$497.52	$479.94	$567.41
50	$333.94	$437.91	$402.63	$434.54	$499.77	$520.85	$502.44	$594.02
51	$348.71	$457.28	$420.44	$453.76	$521.88	$543.89	$524.67	$620.30
52	$364.98	$478.61	$440.05	$474.93	$546.22	$569.26	$549.14	$649.23
53	$381.43	$500.19	$459.89	$496.34	$570.85	$594.92	$573.90	$678.50
54	$399.20	$523.48	$481.30	$519.45	$597.43	$622.62	$600.63	$710.10
55	$416.96	$546.77	$502.72	$542.56	$624.02	$650.33	$627.35	$741.70
56	$436.22	$572.03	$525.94	$567.62	$652.84	$680.37	$656.33	$775.95
57	$455.66	$597.53	$549.38	$592.93	$681.94	$710.70	$685.59	$810.54
58	$476.42	$624.74	$574.41	$619.93	$713.00	$743.07	$716.81	$847.46
59	$486.70	$638.23	$586.81	$633.32	$728.39	$759.11	$732.29	$865.75
60	$507.46	$665.44	$611.83	$660.32	$759.45	$791.48	$763.51	$902.67
61	$525.41	$688.98	$633.47	$683.68	$786.32	$819.47	$790.52	$934.60
62	$537.19	$704.43	$647.67	$699.01	$803.95	$837.85	$808.24	$955.56
63	$551.96	$723.80	$665.48	$718.23	$826.05	$860.88	$830.47	$981.83
64+	$560.93	$735.57	$676.30	$729.91	$839.48	$874.88	$843.97	$997.80

Non-Exchange Plans

Age	Bronze CHA Plus HDP 3	Silver CHA Plus 4	Silver CHA Plus 5	Silver CHA Plus 6	Silver CHA Plus HDP 2	Gold CHA Plus 1	Gold CHA Plus 2	Gold CHA Plus 3	Gold CHA Plus HDP 1
0 – 20	$131.17	$167.20	$159.35	$162.52	$164.52	$202.24	$195.18	$193.57	$198.95
21	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
22	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
23	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
24	$206.57	$263.31	$250.94	$255.94	$259.08	$318.49	$307.37	$304.83	$313.31
25	$207.40	$264.36	$251.94	$256.97	$260.12	$319.77	$308.60	$306.05	$314.57
26	$211.53	$269.63	$256.96	$262.09	$265.30	$326.14	$314.75	$312.15	$320.83
27	$216.49	$275.94	$262.98	$268.23	$271.52	$333.78	$322.13	$319.46	$328.35
28	$224.54	$286.21	$272.77	$278.21	$281.62	$346.20	$334.12	$331.35	$340.57
29	$231.15	$294.64	$280.80	$286.40	$289.92	$356.39	$343.95	$341.11	$350.60
30	$234.46	$298.85	$284.82	$290.50	$294.06	$361.49	$348.87	$345.98	$355.61
31	$239.42	$305.17	$290.84	$296.64	$300.28	$369.13	$356.25	$353.30	$363.13
32	$244.37	$311.49	$296.86	$302.78	$306.50	$376.78	$363.62	$360.62	$370.65
33	$247.47	$315.44	$300.63	$306.62	$310.38	$381.55	$368.23	$365.19	$375.35
34	$250.78	$319.65	$304.64	$310.72	$314.53	$386.65	$373.15	$370.07	$380.36
35	$252.43	$321.76	$306.65	$312.76	$316.60	$389.20	$375.61	$372.50	$382.87
36	$254.08	$323.87	$308.66	$314.81	$318.67	$391.75	$378.07	$374.94	$385.37
37	$255.73	$325.97	$310.66	$316.86	$320.75	$394.29	$380.53	$377.38	$387.88
38	$257.39	$328.08	$312.67	$318.91	$322.82	$396.84	$382.99	$379.82	$390.39
39	$260.69	$332.29	$316.69	$323.00	$326.96	$401.94	$387.91	$384.70	$395.40
40	$264.00	$336.51	$320.70	$327.10	$331.11	$407.03	$392.82	$389.57	$400.41
41	$268.95	$342.82	$326.72	$333.24	$337.33	$414.68	$400.20	$396.89	$407.93
42	$273.71	$348.88	$332.49	$339.13	$343.29	$422.00	$407.27	$403.90	$415.14
43	$280.32	$357.31	$340.52	$347.32	$351.58	$432.19	$417.11	$413.66	$425.17
44	$288.58	$367.84	$350.56	$357.55	$361.94	$444.93	$429.40	$425.85	$437.70
45	$298.29	$380.21	$362.36	$369.58	$374.12	$459.90	$443.85	$440.18	$452.42
46	$309.86	$394.96	$376.41	$383.92	$388.63	$477.74	$461.06	$457.25	$469.97
47	$322.87	$411.55	$392.22	$400.04	$404.95	$497.80	$480.43	$476.45	$489.71
48	$337.74	$430.51	$410.29	$418.47	$423.60	$520.73	$502.56	$498.40	$512.27
49	$352.41	$449.20	$428.10	$436.64	$442.00	$543.35	$524.38	$520.04	$534.51
50	$368.93	$470.26	$448.18	$457.12	$462.72	$568.83	$548.97	$544.43	$559.58
51	$385.25	$491.07	$468.00	$477.34	$483.19	$593.99	$573.25	$568.51	$584.33
52	$403.23	$513.97	$489.83	$499.60	$505.73	$621.70	$599.99	$595.03	$611.59
53	$421.40	$537.14	$511.92	$522.13	$528.53	$649.72	$627.04	$621.86	$639.16
54	$441.03	$562.16	$535.76	$546.44	$553.14	$679.98	$656.24	$650.81	$668.92
55	$460.65	$587.17	$559.59	$570.76	$577.76	$710.24	$685.44	$679.77	$698.69
56	$481.93	$614.29	$585.44	$597.12	$604.44	$743.04	$717.10	$711.17	$730.96
57	$503.41	$641.68	$611.54	$623.74	$631.39	$776.17	$749.07	$742.87	$763.54
58	$526.34	$670.90	$639.39	$652.15	$660.15	$811.52	$783.19	$776.71	$798.32
59	$537.70	$685.39	$653.20	$666.22	$674.40	$829.04	$800.09	$793.48	$815.55
60	$560.63	$714.61	$681.05	$694.63	$703.15	$864.39	$834.21	$827.31	$850.33
61	$580.46	$739.89	$705.14	$719.20	$728.03	$894.96	$863.72	$856.58	$880.41
62	$593.48	$756.48	$720.95	$735.33	$744.35	$915.03	$883.09	$875.78	$900.15
63	$609.80	$777.28	$740.77	$755.55	$764.82	$940.19	$907.37	$899.86	$924.90
64+	$619.71	$789.92	$752.82	$767.83	$777.25	$955.48	$922.12	$914.49	$939.94

GEOGRAPHIC AREA FACTORS

RATING AREA	AREA FACTOR
East	1.530
Greater Knoxville	0.996
Greater Chattanooga	1.451
Greater Nashville	1.009
West	0.998
Greater Memphis	1.001
East Central	1.407
West Central	0.986

SMOKER STATUS

SMOKER STATUS	AREA FACTOR
Non-Smoker	1.00
Smoker	1.25

APPENDIX II
ACTUARIAL VALUE IMPACT OF BENEFIT DIFFERENCES

PLANS TO BE OFFERED ON AND OFF THE EXCHANGE

	BENEFIT DIFFERENCES				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Platinum: CHA 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: Deductible/Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: Deductible/Coinsurance • Urgent Care: $50 Copay	88.6%	0.997	88.3%
Gold: CHA 3 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.5%	0.990	78.7%
Gold: CHA 2 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	82.5%	0.992	81.9%
Gold: CHA HDP 1 EPO	No Differences		78.2%	1.000	78.2%
Silver: CHA 5 EPO	No Differences		69.1%	1.000	69.1%
Silver: CHA 4 EPO	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $55 Copay	72.5%	0.984	71.4%
Silver: CHA HDP 2 EPO	No Differences		71.0%	1.000	71.0%
Bronze: CHA 6 EPO	No Differences		62.0%	1.000	62.0%

PLANS TO BE OFFERED OFF THE EXCHANGE ONLY

	BENEFIT DIFFERENCES (APPLIES TO IN-NETWORK BENEFITS ONLY)				
PLAN	CALCULATOR INPUTS	PROPOSED BENEFIT	ACTUARIAL VALUE (CALCULATOR)	IMPACT OF BENEFIT DIFFERENCE	FINAL ACTUARIAL VALUE
Gold: CHA Plus 1	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	81.3%	0.990	80.5%
Gold: CHA Plus 2	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.8%	0.989	78.9%
Gold: CHA Plus 3	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $100 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $100 Copay, then Coinsurance • Urgent Care: $50 Copay	79.1%	0.989	78.2%
Gold: CHA Plus HDP 1	No Differences		78.8%	1.000	78.8%
Silver: CHA Plus 4	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $50 Copay	72.7%	0.984	71.6%
Silver: CHA Plus 5	• Laboratory Oupatient and Professional Services: 100% • X-Rays and Diagnostic Imaging: 100% • Emergency Room Services: $150 Copay, then Coinsurance	• X-Ray and Lab (Office): 100% • X-Ray and Lab (Hospital): Deductible/Coinsurance • Emergency Room: $150 Copay, then Coinsurance • Urgent Care: $65 Copay	71.7%	0.983	70.5%
Silver: CHA Plus 6	No Differences		69.2%	1.000	69.2%

	Benefit Differences (Applies to In-Network Benefits Only)				
Plan	Calculator Inputs	Proposed Benefit	Actuarial Value (Calculator)	Impact of Benefit Difference	Final Actuarial Value
Silver: CHA Plus HDP 2	No Differences		68.9%	1.000	68.9%
Bronze: CHA Plus HDP 3	No Differences		61.0%	1.000	61.0%

APPENDIX III
PLAN DESCRIPTIONS

Exchange/Off Exchange Plans		Platinum CHA 1 EPO	Gold CHA 2 EPO	Gold CHA 3 EPO	Gold HDP 1 EPO	Silver CHA 5 EPO	Silver CHA 4 EPO	Silver HDP 2 EPO	Bronze CHA 6 EPO
Deductible	Single	$250	$500	$1,250	$1,500	$2,000	$2,000	$1,750	$4,000
	Family	$500	$1,000	$2,500	$3,000	$4,000	$4,000	$3,500	$8,000
Out of Pocket Maximum	Single	$2,250	$4,500	$4,500	$3,000	$6,400	$6,400	$5,250	$6,400
	Family	$4,500	$9,000	$9,000	$6,000	$12,800	$12,800	$10,500	$12,800
Coinsurance		100%	90%	80%	80%	60%	70%	80%	60%
Office/Free Standing Clinic	PCP	$15	$20	$20	Ded/Coins	$35	$25	Ded/Coins	$30
	Specialist	$40	$50	$50	Ded/Coins	Ded/Coins	$55	Ded/Coins	Ded/Coins
	Lab	100%	100%	100%	Ded/Coins	Ded/Coins	100%	Ded/Coins	Ded/Coins
	Xray	100%	100%	100%	Ded/Coins	Ded/Coins	100%	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		Ded/Coins	$250	$100+Coins	$100+Coins	Ded/Coins	$150+Coins	Ded/Coins	Ded/Coins
Urgent Care		Ded/Coins	$50	$50	$50	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
PT/OT/ST		Ded/Coins	Ded/Coins	Coins	Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$10	$10	$10	Ded/Coins	$10	$10	Ded/Coins	Ded/Coins
	Preferred Brand	$25	$30	$30	Ded/Coins	$40	$35	Ded/Coins	Ded/Coins
	Non-Pref Brand	$50	$60	$60	Ded/Coins	$75	$65	Ded/Coins	Ded/Coins
	Specialty	Coins	Coins	Coins	Ded/Coins	Coins	Coins	Ded/Coins	Ded/Coins
Non-Network	Emergency Care Only (Same as In-Network)								

Off Exchange Only Plans		Gold: CHA Plus 1		Gold: CHA Plus 2		Gold: CHA Plus 3	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$1,000	$2,000	$1,000	$2,000	$1,000	$2,000
	Family	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Out of Pocket Maximum	Single	$4,000	$8,000	$4,000	$8,000	$4,500	$9,000
	Family	$8,000	$16,000	$8,000	$16,000	$9,000	$18,000
Coinsurance		80%	60%	70%	50%	70%	50%
Office/Free Standing Clinic	PCP	$20	Ded/Coins	$20	Ded/Coins	$20	Ded/Coins
	Specialist	$45	Ded/Coins	$50	Ded/Coins	$50	Ded/Coins
	Lab	100%	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
	Xray	100%	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room		$100+Coins		$100+Coins		$100+Coins	
Urgent Care		$50	$50	$50	$50	$50	$50
PT/OT/ST		Coins	Coins	Coins	Coins	Coins	Coins
All Other		Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$10	Not Covered	$10	Not Covered	$10	Not Covered
	Preferred Brand	$25	Not Covered	$30	Not Covered	$30	Not Covered
	Non-Pref Brand	$55	Not Covered	$60	Not Covered	$60	Not Covered
	Specialty	Coins	Not Covered	Coins	Not Covered	Coins	Not Covered

Off Exchange Only Plans		Gold: CHA Plus HDP 1		Silver: CHA Plus 4		Silver: CHA Plus 5	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
	Family	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000
Out of Pocket Maximum	Single	$2,000	$6,000	$6,400	$12,800	$6,400	$12,800
	Family	$4,000	$12,000	$12,800	$25,600	$12,800	$25,600
	Coinsurance	100%	70%	70%	50%	60%	40%
Office/Free Standing Clinic	PCP	Ded/Coins	Ded/Coins	$25	Ded/Coins	$35	Ded/Coins
	Specialist	Ded/Coins	Ded/Coins	$50	Ded/Coins	$65	Ded/Coins
	Lab	Ded/Coins	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
	Xray	Ded/Coins	Ded/Coins	100%	Ded/Coins	100%	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Emergency Room	Ded/Coins		$150 + Coins		$150 + Coins	
	Urgent Care	Ded/Coins	Ded/Coins	$50	$50	$65	$65
	PT/OT/ST	Ded/Coins	Ded/Coins	$50	$50	$65	Ded/Coins
	All Other	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	Ded/Coins	Not Covered	$10	Not Covered	$10	Not Covered
	Preferred Brand	Ded/Coins	Not Covered	$40	Not Covered	$40	Not Covered
	Non-Pref Brand	Ded/Coins	Not Covered	$75	Not Covered	$75	Not Covered
	Specialty	Ded/Coins	Not Covered	Coins	Not Covered	Coins	Not Covered

Off Exchange Only Plans		Silver CHA Plus 6		Silver CHA Plus HDP 2		Bronze CHA Plus HDP 3	
		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible	Single	$2,000	$4,000	$2,000	$4,000	$5,500	$8,000
	Family	$4,000	$8,000	$4,000	$8,000	$11,000	$16,000
Out of Pocket Maximum	Single	$6,400	$12,800	$6,000	$12,000	$5,500	$12,000
	Family	$12,800	$25,600	$12,000	$24,000	$11,000	$24,000
	Coinsurance	70%	50%	80%	60%	100%	70%
Office/Free Standing Clinic	PCP	$35	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Specialist	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Xray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Hospital	IP	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	OP Surg	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Surgeon	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Major DX	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Lab/X-Ray	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	Emergency Room	Ded/Coins		Ded/Coins		Ded/Coins	
	Urgent Care	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	PT/OT/ST	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
	All Other	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Pharmacy	Generic	$15	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Preferred Brand	$45	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Non-Pref Brand	$75	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered
	Specialty	Coins	Not Covered	Ded/Coins	Not Covered	Ded/Coins	Not Covered

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
06/13/2013		Supporting Document	Modified Plan and Benefits	06/14/2013	ModifiedPlanandBenefitChart_Group_OffExchange.xlsx (Superceded)
06/13/2013		Form	Group EOC OutofNetwork	06/14/2013	TN Group EOC OON Final.pdf (Superceded)
06/13/2013		Form	Group POS Schedules	06/14/2013	Group POS Schedules.pdf (Superceded)
06/13/2013		Rate	CHA Group Rates	06/14/2013	CHA Group_SERFF Format.xls (Superceded)

State:	Tennessee	**Filing Company:**	Community Health Alliance Mutual Insurance Company
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other		
Product Name:	CHA Small Group		
Project Name/Number:	/		

Attachment ModifiedPlanandBenefitChart_Group_OffExchange.xlsx is not a PDF document and cannot be reproduced here.

Attachment CHA Group_SERFF Format.xls is not a PDF document and cannot be reproduced here.

EVIDENCE OF COVERAGE AND

SUMMARY PLAN DESCRIPTION

IN-NETWORK & OUT-OF-NETWORK GROUP BENEFIT PLAN

COMMUNITY HEALTH ALLIANCE MUTUAL INSURANCE COMPANY

PLEASE READ THIS EVIDENCE OF COVERAGE AND SUMMARY PLAN DESCRIPTION CAREFULLY. KEEP IT IN A SAFE PLACE. IT EXPLAINS YOUR COVERAGE FROM COMMUNITY HEALTH ALLIANCE. IF YOU HAVE ANY QUESTIONS, PLEASE CALL OR WRITE CUSTOMER SERVICE, OR YOU MAY VISIT OUR WEBSITE AT: www.chatn.org

COMMUNITY HEALTH ALLIANCE
MUTUAL INSURANCE COMPANY
445 S. GAY ST. SUITE 101
KNOXVILLE, TN 37421
865-862-4164

THIS IS ONLY A SUMMARY

This Evidence of Coverage and Summary Plan Description ("EOC") is part of the Group Agreement between Community Health Alliance and Your Group. This EOC describes the terms and conditions of Your coverage from the Plan through the Group, and includes all riders and attachments, included as part of this EOC. It replaces any EOC that You previously received from the Plan.

Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not covered by the Plan. Other Covered Services are limited unless pre-approved by the Plan. The Plan will not pay for any service not specifically listed as a covered service, even if a health care provider recommends or orders that non-covered service.

The Group has given authority to the Plan to make any benefit or eligibility decisions. It has also granted the authority to construe the terms of Your coverage to the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such decisions.

Please contact a Customer Service representative at the number listed on Your membership ID card if You have any questions regarding this EOC or any other matters related to Your coverage from the Plan.

The benefits described in this EOC are referred to as "the Health Plan," or simply "the Plan."

PLAN TERMS

This EOC describes the Plan as of January 1, 2014.

RIGHT TO AMEND OR TERMINATE

The Plan has the right, at any time, to amend or terminate the Plan, as described on page 54 in the *General Information* section of this EOC.

RIGHT TO INTERPRET

The Plan has full discretion to make factual determinations and to interpret the Plan.

MODIFICATIONS NOT PERMITTED

The legal documents governing the Plan cannot be modified by oral statements made by anyone, or by unofficial communications, such as e-mail or mailings. The Plan can only be modified by official Plan amendments.

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ELIGIBILITY AND ENROLLMENT

WHEN COVERAGE BEGINS AND ENDS

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY

If You're part of this group…	You are eligible to participate in the Plan if …
Employee	You are a full-time salaried employee as defined by the Plan Sponsor.

EXCLUSIONS

Independent contractors, leased employees, and any persons shown on the records of the Plan Sponsor as independent contractors or leased employees are not eligible to participate in the Health Plan.

No person is eligible to re-enroll in the Plan if the Plan previously terminated his or her coverage for cause.

DEPENDENT ELIGIBILITY

If You are eligible for coverage, You may also cover Your Eligible Dependents under the Plan. Social Security numbers are required for enrollment of all dependents. Eligible Dependents are:

- Your spouse. Your spouse is Your current husband or wife as recognized by Tennessee law.
- Your Domestic Partner. Tax consequences may exist for coverage of Domestic Partners.
- Your children 26 and Younger

  Your children are:

  - Your natural or lawfully adopted children (including children placed for adoption), stepchildren and persons for whom You are the legal guardian;
  - Children for whom You are responsible for coverage under the terms of a court decree a Qualified Medical Child Support Order (a QMCSO).
- Your unmarried children over age 26 who are unable to support themselves because of a permanent mental or physical handicap and are dependent on You for support and maintenance, and are considered dependents for income tax purposes. These children must have been covered by this Plan prior to reaching age 26. You must provide proof of the child's disability to the Plan within 31 days after his or her coverage would end. Thereafter, You must provide proof of the disability once a year after the two year period following the child reaching age 26.

Individuals who permanently reside outside the United States are not eligible for coverage under this Plan.

The Plan's determination of eligibility under the terms of the Plan shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to: a certified copy of any QMCSO or certification.

HOW TO ENROLL

You will receive information on how to enroll. You will use the benefits election process to enroll in (or decline) the Plan. You must enroll within 31 days after You become eligible under the Plan. Also, You must enroll any Eligible Dependent(s) within 31 days after they become eligible to participate in the Plan.

PREMIUMS

You may be required to pay for some or all of the Premiums for coverage under this Plan. If You do not pay all of the Premium, the rest may be paid by the Plan Sponsor or, if applicable, Your Advanced Premium Tax Credit (APTC).

If You receive an APTC and have not paid Your Premium when due, you are entitled to a grace period of 3 months in a row to pay Your Premium. This grace period will apply only if You have paid a least one full month's Premium during the Plan Year. Coverage will continue during the first month of the grace period, but the Plan will suspend payment of claims for any Covered Services during the second and third months of the grace period if no Premium payments are made. If the grace period of 3 months ends without You paying all outstanding Premiums, coverage will end as set forth in the "When Your Coverage Ends" section below.

If You do not receive an APTC, You are entitled to a grace period of 31 days for payment of Your Premium, except for the first Premium due. Coverage will continue during the grace period, unless You provide the Plan with written notice of prospective cancellation in accordance with the terms of the Plan. You may be liable for a prorated Premium for coverage provided during the grace period.

You will be provided with written notice at least 31 days prior to the date any increase in Premium rate would become effective.

IF BOTH YOU AND YOUR SPOUSE ARE ENROLLED IN THE PLAN

Married couples may enroll in whatever combination of single or married coverage that meets their needs. However, under the same Plan Sponsor, no individual may be covered as both an individual and a dependent, and dependents cannot be covered by more than one individual.

ANNUAL ENROLLMENT: NEW EMPLOYEE

Your election to participate or not participate in the Health Plan will continue each year unchanged, unless You actively elect to change Your election during Annual Enrollment, at which time You may:

- elect coverage if You previously declined it; or
- elect a different Plan option.

Changes made during Annual Enrollment are effective January 1st immediately following Annual Enrollment.

CHANGING YOUR COVERAGE

Because of the tax advantages that apply to the Plan, federal laws restrict Your ability to change Your elections once they are effective. These laws govern the types of changes that You may make during the Plan Year. In general, once You enroll for (or decline) coverage, Your benefit elections and Covered

Dependents stay in effect until You change them at Annual Enrollment.

However, under certain circumstances, You may enroll in the Health Plan or add or remove Covered Dependents during the Plan Year. Except as allowed, You cannot change from one coverage option to another. If You have an event permitting a mid-year change, You may make changes to any of Your elections, subject to certain exceptions and limits explained below. However, any changes must be consistent with the triggering event.

CONSISTENCY RULE

For change in status elections under the Health Plan, any election change You make must affect eligibility under the Health Plan. In addition, regardless of what event You have, any election change You make must be because of and consistent with the event. For example, You can elect to cover Your spouse following Your marriage or Your child following an adoption.

The Plan Administrator, in its sole discretion, will determine whether an event permits an election change and, if so, whether the election change is consistent with the event, in accordance with rules established by the IRS.

ELECTION PERIOD FOR CHANGING COVERAGE AND EFFECTIVE DATE OF COVERAGE

If You have an event permitting You to change Your Health Plan coverage, You must notify the Plan and make Your election changes within 31 days of the event. If timely made, coverage changes made due to a mid-year event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are generally effective as of the date of the event. However, for HIPAA special enrollment of a child as the result of birth, adoption or placement for adoption, coverage will be effective as of the date on which You acquire the child.

If You do not make a timely election, You will not be able to make a mid-year election and will have to wait until Annual Enrollment to make any election changes.

CHANGE IN STATUS

You can change Your Health Plan coverage during the year if a change in status occurs that affects eligibility for coverage under the Health Plan or under another employer's group health Plan (such as the Plan of a Dependent's employer). A change in status is any of the following:

- Your marriage, divorce, legal separation or annulment;
- the birth, adoption, or placement for adoption of a child;
- a change in Your spouse's employment or involuntary loss of health coverage under another employer's plan (other than coverage under the Medicare or Medicaid programs);
- the death of an Eligible Dependent;
- Your Dependent child no longer qualifying as an Eligible Dependent;
- a change in Your or Your spouse's position or work schedule that affects eligibility for health coverage;
- a strike or lockout involving You or Your Spouse; or
- a court or administrative order.

Note: Any child under age 26 who is placed with You for adoption will be eligible for coverage on the date the child is placed with You, even if the legal adoption is not yet final. If You do not legally adopt the child, all Health Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

CHANGE IN FAMILY STATUS EXAMPLE

Jane is married and has two children who qualify as Eligible Dependents. At Annual Enrollment, she elects not to participate in the Plan, because her husband, Tom, has coverage for her and the children under his employer's medical Plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect to add her Eligible Dependents under the Plan outside of Annual Enrollment.

HIPAA SPECIAL ENROLLMENT

Under HIPAA, You have the right to enroll Yourself and Your Eligible Dependents for medical coverage, even if You were not already enrolled, within 31 days after the following special enrollment events:

- You declined medical coverage because You or Your Dependent had other coverage as stated in writing as the reason for declining coverage in this Plan and the other coverage ends because:
  - o You or Your Dependent are no longer eligible for such coverage (whether such coverage was provided through another employer, private insurance or otherwise);
  - o You or Your Dependents exhaust COBRA coverage under another employer's group health Plan (other than due to a failure to pay Premiums or for cause); or

- Employer Premiums toward the other group health Plan coverage terminate.

- You acquire a Dependent as a result of a marriage, birth, adoption, placement for adoption, or appointment of legal guardianship. Coverage for a Dependent child will be effective from: the moment of birth; the date of adoption or placement for adoption; and the moment the child is placed in Your physical custody as legal guardian. If the child is not enrolled within 31 days from the date You acquire the child and an additional Premium is required, the Plan will not cover the child after the 31 days.

- You or Your Dependent lose coverage under Medicaid or a state child health Plan under Title XXI of the Social Security Act, or You or Your Dependent gains eligibility for Premium subsidy assistance under Medicaid or a state child health Plan. In the case of loss of Medicaid or a state child health Plan, if You timely enroll, coverage will take effect on the first day of the month following enrollment.

If You do not request the change within 31 days (60 days for loss of coverage under Medicaid or a state child health Plan) of Your special enrollment event, You lose the right to enroll for that event. If You already have Health Plan coverage when a special enrollment right applies to You, You may elect to switch medical options.

ENROLLMENT PURSUANT TO A QMCSO

You, a custodial parent or a state agency may enroll Your Dependent child in health care coverage, under the terms of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, which is determined to be a (QMCSO). Alternatively, coverage for a Dependent child may be revoked if the QMCSO requires the spouse, former spouse or another individual to provide coverage for the child. Only the child who is eligible for coverage under a QMCSO may be enrolled for or dropped from coverage.

A Dependent child can be enrolled for health care coverage under a QMCSO only if any required Premiums are made. This means that any required contribution for Your Dependent child's coverage will be withheld from Your paycheck unless a state agency pays the required contribution. In addition, coverage will be effective as soon as administratively possible following the Plan Administrator's determination that the order is valid.

An existing QMCSO may be revoked by a similar order. In this case, You may drop Your covered Eligible Dependent by contacting the Plan within 31 days of the new order. If the child is not Your Eligible Dependent when the new order is issued, coverage will automatically end.

MEDICARE OR MEDICAID ENTITLEMENT

If You, Your spouse or other Dependent becomes entitled to Medicare or Medicaid coverage, You can drop Health Plan coverage for Yourself or that individual. In contrast, if You, Your spouse or other Dependent loses Medicare or Medicaid coverage, You may enroll for Health Plan coverage for Yourself or that individual.

SIGNIFICANT COST OR COVERAGE CHANGES

A number of events come under this category, and are described below. Please note any change must be requested within 31 days of the event.

- The cost of coverage for a benefit option significantly increases or significantly decreases during the Plan year (including if the significant cost change occurs under Your spouse's employer Plan).

  The Plan Sponsor, in its discretion, makes a determination whether an increase or decrease is significant enough to trigger a right to make mid-year election changes. Any insignificant increases or decreases, as determined by the Plan Sponsor, in the cost of coverage will be made automatically.

  If cost for a coverage option in which You do not participate significantly decreases, You can make an election to participate in that coverage option. In contrast, if the cost for Your elected coverage option significantly increases, You can select another coverage option providing similar coverage. If no option provides similar coverage, then You can drop coverage.

- An event occurs that significantly decreases coverage or causes You to lose coverage under Your current coverage option.

  A significant decrease of coverage can include such things as a large increase in the deductible, the copay or coinsurance amounts, and results in an overall reduction in coverage.

  An event that may cause You to lose coverage can include such things as elimination of a coverage option.

  These events allow You to change Your coverage option to another

coverage option providing similar coverage. If no similar coverage is available, then You may end coverage.

- A coverage option is added or becomes much better during the Plan year and You are eligible for it.

  In this event, even if You did not enroll for coverage, You can elect coverage under the new or better option.

- You or Your Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution.

  This event allows You or Your Dependent to enroll for coverage. Note that if You gain eligibility for group health coverage sponsored by a governmental or educational institution, You may not drop Your Health Plan coverage.

- The change corresponds with a change made by You or Your Dependent under another employer Plan in the following circumstances:

  - If the annual enrollment period under the other employer Plan occurs at a different time of year than this Plan's Annual Enrollment and the other employer Plan has a period of coverage that is different than the calendar year period of coverage provided under the Health Plan; or

  - If the other employer Plan allows You or Your Dependent to change elections due to the reasons above (change in status, special enrollment, QMCSO, Medicare or Medicaid entitlement and major cost or coverage changes).

NON-DISCRIMINATION

Eligibility, including continued eligibility, will not be based on Your or Your Dependents health status or any of the following related factors:

- Health status;
- Medical condition, including both physical and mental illnesses;
- Claims experience;
- Receipt of health care;
- Medical history;
- Genetic information;
- Evidence of insurability, including conditions arising out of acts of domestic violence; or
- Disability.

You will not be required to pay a Premium which is greater than the Premium for a similarly situated individual enrolled in the Plan on the basis of any health status related factor of Yourself or Your Dependent, unless allowed by law.

WHEN COVERAGE BEGINS AND ENDS

WHEN YOUR COVERAGE BEGINS

Your coverage begins on the earliest of the following dates, subject to the Actively at Work Rule set out below:

- The date You become eligible, if You enroll on or before that date or within 31 days after that date;
- The first day of January of the year following the end of any Annual Enrollment Period during which You enroll; or
- The first day of the month after the Plan receives Your enrollment form.

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

Your Dependents' coverage begins on one of the following dates:

- The date You become eligible to cover Your Dependents, if You enroll them within 31 days after that date;
- The date You acquire an Eligible Dependent by birth, adoption or placement for adoption, provided You make written application for the Dependent and agree to pay any required Premiums, within 31 days of the date of eligibility;
- The first day of the month following the date You acquire the Eligible Dependent (other than by birth, adoption or placement for adoption), provided You make written application for the Dependent and agree to pay any required Premiums, within 31 days of the date of eligibility;
- The date indicated in a QMCSO, if You enroll Your Dependent within 31 days of the court order; or
- January 1st of the year following the end of any Open Enrollment Period during which enrollment for the Eligible Dependent has been made.

ACTIVELY AT WORK RULE

If You are not Actively at Work on the date coverage would become effective, coverage for You and Your Covered Dependents will be delayed until the date You are Actively at Work. If You are not at work on the date coverage would become effective due to a health-related factor, You shall be treated as Actively at Work for purposes of determining eligibility.

WHEN YOUR COVERAGE ENDS

Your coverage under the Plan will end:

- On the date You no longer meet the Plan's eligibility requirements;
- On the date the Plan ends or is terminated;
- On the date You are terminated for cause due to the following: the Plan has not received the required Premium for Your coverage (the fact that You have paid a Premium to the Plan Sponsor will not prevent the Plan from terminating Your coverage if the Plan Sponsor fails to submit the full Premium for Your coverage to the Plan when due); You fail to make a required Member payment; You fail to cooperate with the Plan as required by this EOC; or You omit or provide incorrect or misleading information, or commit fraud against the Plan (this includes, but is not limited to permitting the improper use of Your membership ID card); or
- On the last date Your Premium is paid through.

In addition, if You receive an APTC and do not pay all outstanding Premiums by the end of your 3 month grace period, Your coverage will end on the last day of the first month of the 3 month grace period.

WHEN YOUR DEPENDENTS' COVERAGE ENDS

Coverage for Your Dependents ends on the earliest of the following dates:

- On the date Your coverage ends.
- On the date the Dependent no longer qualifies as an Eligible Dependent.
- On the date Your Dependent becomes covered as an individual.
- On the date indicated in a QMSCO.
- On the date the Plan ends or changes,

PAYMENT FOR SERVICES RECEIVED AFTER TERMINATION OF COVERAGE

If You receive Covered Services after the termination of Your coverage, the Plan may recover from You the amount it paid for such services, plus any costs of recovering such charges, including attorney's fees.

EXTENDED BENEFITS

If You are hospitalized on the date the Plan is canceled, benefits for Hospital Services will be provided: for 60 days; until You are covered under another Plan; or until You are discharged, whichever occurs first. This paragraph will not apply to Your newborn child if You do not apply for coverage for that child within 31 days following the child's birth.

THE
HEALTH PLAN

HIGHLIGHTS OF THE HEALTH PLAN

This EOC is a summary of the Plan. The EOC describes the Plan, as of January 1, 2014.

The Health Plan offers health services through a network of providers that have agreed to charge Members negotiated rates for health care. The specific services that are covered under the Plan, and the limits that apply, are described in this EOC. You are required to use an In-Network Provider for Covered Services, except in the case of an Emergency.

THE HEALTH PLAN

- lets **You** choose Your own In-Network Provider. You are required to use an In-Network Provider for all Covered Services except in the case of Emergency;
- covers qualifying preventive care services at 100% at a Network Provider (see the *Schedule of Benefits* for each Plan option for specifics);
- offers the added benefit of health resources to help You make informed decisions about Your family's health care purchases. For more information, visit www.chatn.org; and
- contracts with providers who agree not to Balance Bill you for the difference between the amount they charge and the amount the Plan pays, except for any required Coinsurance, Copayments or Deductibles.

CHANGING COSTS

The Plan reserves the right to change Your cost of coverage annually. Generally, Premiums changes are announced each year during Annual Enrollment.

Please read this EOC thoroughly to learn how the Health Plan works.

If you have questions, please call Customer Service at the number listed on your Plan ID card.

YOUR COSTS UNDER THE HEALTH PLAN

DEDUCTIBLE

The Plan may require You to satisfy an up-front Plan Year Deductible, as stated in the *Schedule of Benefits*, before the Plan begins to pay. The Deductible does not apply to certain preventive care services received from a Network Provider.

If You cover Yourself and Dependent(s), and one or more family members together incur Covered Expenses to meet the family Deductible, no further Deductible will be required from any family member for the rest of the Plan Year.

There are two separate Deductible amounts, one for Network Providers and one for Out-of-Network Providers.

Copayments and any balance of charges are not considered when determining if You have satisfied a Deductible.

Note: The Deductible is sometimes referred to as *Member responsibility*.

COINSURANCE

Once You meet the Plan Year Deductible, Health Coverage pays the percentage, as shown in the *Schedule of Benefits*, for additional health care Covered Expenses. You pay any remaining percentage, which is Your Coinsurance.

COPAYMENTS

A Copayment is a fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

MAXIMUM OUT OF POCKET

The Maximum Out of Pocket (MOOP) is the most You will pay before the Plan begins to pay 100% of the cost of Covered Services for the rest of the Plan Year for a Network Provider and 100% of Usual and Customary for an Out-of-Network Provider, subject to the Maximum Individual Limit or other exclusions.

There are two MOOP amounts, one for services rendered by Network Providers and one for services rendered by Out-of-Network Providers.

Expenses paid to satisfy the Plan Year Deductible, Copayments, Coinsurance payments or any variation of these paid expenses will be used to meet the MOOP. Please see the Schedule of Benefits in the Exhibit to this Plan for details about Your Copayment and Coinsurance amounts. If You cover one or more family members, expenses for all of Your family members combined will apply to Your Plan Year family MOOP.

PREVENTIVE CARE SERVICES

Qualified Preventive Care Services are covered at 100% if received from a Network Provider**.** Qualifying preventive care services and benefits are covered with no Deductible, Co-payment, or Coinsurance.

For a complete list of qualifying preventive care services, see the section entitled, *Preventive Care Services – Schedule of Benefits* in the Exhibit. You may receive other preventive care services or choose to receive preventive care services from an Out-of-Network Provider; however, any such services will not be covered or may be considered as any other claim.

BALANCE BILLING

Network Providers should not Balance Bill You for Covered Services. This means that You should not have to pay for the difference between what they charge and what the Plan pays, except for any required Coinsurance, Copayments or Deductibles

HEALTH RESOURCES

IMPORTANT INFORMATION ABOUT THE MATERIAL FOUND IN THIS SECTION

Information obtained through the services identified throughout this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information you receive from these services is intended to help you make better health care decisions.

The Plan is not responsible for the results of any decisions You make from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text of the current medical literature.

PATIENT SUPPORT

The goal of the care management program is to support Your health care needs and educate You about Your benefits and available resources.

Nurses provide a variety of different services to help You and Your covered family members receive appropriate medical care. The Program requirements are subject to change without notice. Services may include:

- **Admission counseling** – For upcoming inpatient hospital admissions, a health coach may call You to answer questions and to make sure You have information to support Your recovery.
- **Inpatient care advocacy** – If You are hospitalized, a health coach may work with Your treatment team to make sure You are getting the care You need and that Your treatment Plan is being carried out effectively.

Transition of Care – After leaving the hospital You may receive a phone call from a nurse if You have certain chronic or complex conditions. This program serves as a bridge for improved coordination of care between facility to facility or home transfers or facility to home. The nurse will also confirm Your medications, any required equipment, and make sure that follow-up services are in place.

If You do not receive a call from a nurse but feel You could benefit from any of these programs please call Customer Service at the number listed on Your Plan ID card.

PREAUTHORIZATION

Some services require prior authorization from the Plan. Your Provider must get this prior authorization. If Your Provider fails to obtain prior authorization, Your claim for benefits may be reduced or denied. The services and devices for which Your Provider is required to obtain prior authorization include, but are not limited to:

- Observation in a hospital
- All non-emergent inpatient admissions, including:
    - Inpatient rehabilitation facility
    - Skilled nursing facility (up to 30 days if medically necessary)
    - Mental health
    - Substance abuse facilities
- Purchased durable medical equipment over $500
- All rented durable medical equipment.
- Home care services including infusion therapy
- Orthopedic footwear, shoe modifications and additions when costs exceed $300
- Some surgical/interventional services performed in an outpatient hospital or ambulatory surgery setting including but not limited to:
    - Chemotherapy
    - Cosmetic procedures
    - Dental, jaw and face procedures
    - Dental/oral surgery requiring general anesthesia
    - Oral pharynx procedures
    - Nuclear cardiology tests
    - Abortion
    - Hysterectomy
    - Genetic testing
    - Hyperbaric oxygen therapy
    - Infusion Centers
    - OB ultrasounds exceeding three per pregnancy
    - Pain management programs including epidurals, nerve blocks, facet injections, pain management pumps, dorsal column stimulators
- Chiropractic services in excess of 6 visits annually
- Physical therapy after the tenth visit
- Occupational therapy after the tenth visit
- Speech therapy after the tenth visit
- Cardiac and Pulmonary rehabilitative services
- Developmental Evaluation and Treatment Services

- Respiratory therapy services except for initial evaluation
- MRI, MRA, MRS, MRT when not performed in the emergency room or as part of an approved inpatient confinement
- PET or SPEC scans when not performed in the emergency room or as part of an approved inpatient confinement
- CT, CTA scans when not performed in the emergency room or as part of an approved inpatient confinement
- Transplant services
- Hospice
- Implantable devices including cochlear implants
- Sleep studies, sleep therapies and supplies

For a complete list of services requiring prior authorization, please visit www.chatn.org.org.

RESOURCES TO HELP YOU STAY HEALTHY

The Plan believes in giving You the tools You need to be an educated health care consumer. The Plan has several convenient phone and internet educational and support services accessible by both phone and internet, which can help You to:

- take care of Yourself and Your family members
- manage a chronic health condition
- navigate the complexities of the health care system

HEALTH RESOURCES WEBSITE

www.chatn.org provides information anywhere and anytime You have access to the internet. The member website opens the door to a wealth of health information and convenient self-service tools.

REGISTERING ON WEBSITE

If You have not already registered as a member go to www.chatn.org. Have Your card handy. The enrollment process is quick and easy.

If You do not know Your logon ID, contact the Plan's Customer Service. The phone number is located on Your ID card.

HEALTH INFORMATION

You can:

- Search for Network Providers through the online Provider directory
- Research a health condition and treatments to get ready for a visit with Your Physician
- Access wellness topics from Health Coaches
- Complete a health risk assessment to learn about areas of Your health that can be improved so You can live a longer and more productive life.
- Use the treatment cost estimator to estimate the cost of a procedure.

SELF-SERVICE TOOLS

Visit www.chatn.org to:

- make real-time inquiries into the status and history of Your claims
- view eligibility and Plan benefit information, including deductibles
- view and print all of Your Explanation of Benefits (EOBs)
- order a new or replacement ID card

If You do not have access to a computer, You can get the same information by contacting a Customer Service representative at the number on Your ID card.

DISEASE MANAGEMENT PROGRAM

Disease Management (DM) is a program to support You and Your Eligible Dependents. In DM, members will work with health coaches to set goals, discuss treatment options and improve Your overall health. Through health coaching, You will also get guidance on maintaining a healthy lifestyle and how to follow treatment and medication Plans. DM is available at no cost to all Members and their Eligible Dependents. There are DM programs for:

- Coronary Artery Disease
- Diabetes
- Depression
- Attention Deficit with Hyperactivity Disorder (ADHD)

LIFESTYLE MANAGEMENT

Lifestyle Management is health coaching designed to help participants reach their individual health goals. Lifestyle changes are hard and whether You are making a small change or a large one; coaching can make a huge difference in helping You reach Your health goals. Lifestyle Management programs may include:

- Nutrition
- Exercise
- Blood Pressure
- Cholesterol
- Tobacco Cessation
- Weight Management
- Stress Management
- Back Care

WHAT'S COVERED UNDER THE HEALTH PLAN

The Plan covers many Medically Necessary services and supplies, subject to any limits or exclusions below. However, the Plan only covers care provided by healthcare professionals or facilities that are licensed, certified or otherwise qualified under state law to provide healthcare services.

PREVENTIVE CARE SERVICES

The following is a list of services required by the Patient Protection and Affordable Care Act and included in the United States Preventive Services Task Force (USPSTF) A and B Recommendations, as amended from time to time. When you receive these services from a Network Provider, the Plan pays 100% without You paying any Deductible or Coinsurance.

If You do not receive these services from a Network Provider, Deductible and Coinsurance will apply.

WELL-CHILD CARE

Well-child care includes:

- Alcohol and Drug Use – annual assessments for adolescents;
- Autism – screening for children at 18 and 24 months;
- Behavioral – annual assessments for children of all ages;
- Blood Pressure – annual screening for children age 0-18;
- Cervical Dysplasia – annual screening for sexually active females;
- Congenital Hypothyroidism – screening for newborns;
- Developmental – screening for children under age 3 and surveillance throughout childhood;
- Dyslipidemia – annual screening for children at higher risk of lipid disorders;
- Fluoride Chemoprevention – fluoride supplements prescribed by a Primary Care Physician for preschool children older than 6 months whose primary water source is deficient in fluoride;
- Gonorrhea – prophylactic ocular topical medication for all newborns;
- Hearing – screening for hearing loss in all newborns;
- Hematocrit or Hemoglobin – annual screening for children;
- Hemoglobinopathies – screening for sickle cell disease in newborns;
- Hypothyroidism – screening for congenital hypothyroidism in newborns;
- Immunization – vaccines for children from birth to age 18, recommended ages, frequency and populations will vary with each vaccine;
- Iron – supplements for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia;
- Lead – annual screening for children at risk of exposure;
- Obesity – annual screening and counseling for children age 6 and older;
- Phenylketonuria (PKU) – screening for PKU in newborns;
- Skin Cancer – behavioral counseling for children, adolescents and young adults ages 10-24 who have fair skin about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer;
- Tuberculin – testing for children at higher risk of tuberculosis;
- Vision – screening for all children at least once between the ages 3-5 to detect the presence of amblyopia or its risk factors.

WELL-ADULT CARE

Well-adult care includes:

- Abdominal Aortic Aneurysms – one-time screening for men age 65-75 who have ever smoked;
- Alcohol Misuses – annual screening and counseling in primary care settings;
- Aspirin – use to prevent myocardial infarctions in men age 45-79 and women age 55-79;
- Blood pressure – annual screening for all adults over the age of 18;
- Cholesterol – annual screening for men age 35 and above, for men age 20-35 if they are at increased risk for coronary heart disease, for women age 45 and above, for women age 20-45 if they are at increased risk for coronary artery disease;
- Colorectal cancer – annual screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy for adults age 50-75;
- Depression – annual screening for adolescents age 12-18 for major depressive disorder and adults for depression;
- Type 2 Diabetes – annual screening for adults with sustained high blood pressure;
- Diet – annual counseling for adults at higher risk for diet-related chronic disease;
- Falls prevention – exercise or physical therapy to prevent falls

and vitamin D supplementation in community-dwelling adults age 65 and older who are at increased risk for falls;

- Human Immunodeficiency Virus (HIV) – annual screening for all adolescents and adults at increased risk for HIV infection;
- Immunizations – Vaccines for adults, recommended ages, frequency and populations will vary with each vaccine;
- Obesity – screening for obesity with an offer or referral to intensive, multicomponent behavioral interventions for patients with a body mass index of 30 kg/m^2 or higher;
- Sexually Transmitted Infection (STI) – annual prevention counseling for sexually active adolescents and adults at increased risk for STIs;
- Tobacco Use – annual screening for all adults and cessation interventions for tobacco users;
- Syphilis – annual screening for all adults at increased risk for syphilis infection.

WELL-WOMAN CARE

Well-woman care includes:

- Anemia – screening in asymptomatic pregnant women;
- Bacteriuria – urinary tract or other infection screening for pregnant women at 12-16 weeks gestation or the first prenatal visit, whichever is later;
- Breast Cancer Susceptibility Gene Testing (BRCA) – counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 and BRCA2 genes;
- Mammography – screenings once as a baseline for women at least 35 but less than 40, once every 2 years for women at least 40 but less than 50, once per year for women at least 50, or in accordance with the most recent published guidelines of the American Cancer Society;
- Chemoprevention – counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention;
- Breastfeeding – support and counseling from trained providers during pregnancy and after birth to promote and support breastfeeding and access to breastfeeding supplies for pregnant and nursing women in conjunction with each birth;
- Cervical Cancer – screening in women ages 21-65 with cytology (pap smear) every 3 years or, for women ages 30-65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years;
- Chlamydia Infection – annual screening for all sexually active non-pregnant women age 24 and younger, older non-pregnant women at increased risk, pregnant women age 24 and younger, and older pregnant women who are at increased risk;
- Contraception – Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed, not including abortifacient drugs;
- Domestic and Interpersonal Violence – annual screening and counseling for all women;
- Folic Acid – supplements for women planning or capable of pregnancy;
- Gestational Diabetes – screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea – annual screening for all women at increased risk for infection;
- Hepatitis B – annual screening for pregnant women at their first prenatal visit;
- Human Immunodeficiency Virus (HIV) – annual screening and counseling for sexually active women;
- Human Papillomavirus (HPV) DNA Test – High-risk HPV DNA testing every three years for women with normal cytology results who are 30 or older;
- Intimate partner violence screening – screening for women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This applies to women who do not have signs or symptoms of abuse;
- Osteoporosis – screening for osteoporosis in women age 65 and older and in younger women whose fracture risk is equal or greater than that of a 65 year old white woman who has no additional risk factors;
- Rh Incompatibility – screening for all pregnant women during their first prenatal visit and follow-up testing for women at higher risk at 24-28 weeks gestation;
- Tobacco Use – annual screening and interventions for all women and expanded counseling for pregnant tobacco users;
- Syphilis – screening for all pregnant women;
- Well-Woman Visits – annual visits to obtain recommended preventive services.

It is important to note that any qualifying preventive care services that fall outside of the above lists, including all prescriptions, or services received from an Out-of-Network Provider will not be payable at 100%; however, will be considered for coverage under the Plan's Deductible, Coinsurance and coverage components.

STANDARD SERVICES COVERED UNDER HEALTH COVERAGE

The Plan covers a wide range of medical expenses, provided they are rendered by an In-Network Provider and are determined to be Medically Necessary or usual to the treatment of an Illness or Injury, as determined by the Plan's medical staff or an independent medical Physician review panel.

When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet your needs, the Plan reserves the right to provide payment for the least expensive Covered Service alternative.

The following is a listing of Covered Expenses payable under the Plan:

AMBULANCE SERVICES

Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to you. Covered Services include:

- Medically Necessary and Appropriate land or air transportation to or from the scene of an accident or Emergency.

BEHAVIORAL HEALTH

Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Covered Services include:

- Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders;
- Treatment of medical conditions underlying, or resulting from, behavioral health disorders.

DENTAL SERVICES

- Medically Necessary and Appropriate services performed by a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD) or any Physician licensed to perform dental related oral surgery except as indicated herein. Covered Services include: Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident;
- For dental services not listed above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are covered, only when one of the 5 conditions listed below is met:
  - Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;
  - Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
  - Mental illness or behavioral condition that precludes dental surgery in the office;
  - Use of general anesthesia and the member's medical condition requires that such procedure be performed in a Hospital; or
  - Dental treatment or surgery performed on a member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.
- Oral appliances to treat obstructive sleep apnea, if Medically Necessary.
- Routine dental services for children under age 18.

DIABETES TREATMENT

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be covered, such services must be prescribed and certified by a Physician as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. Covered Services include:

- Blood glucose monitors, including monitors designed for the legally blind;
- Test strips for blood glucose monitors;
- Visual reading and urine test strips;
- Insulin;
- Injection aids;
- Syringes;
- Lancets;
- Oral hypoglycemic agents;
- Glucagon emergency kits;
- Injectable incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with

selected Prescription Drugs for the treatment of diabetes;
- Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is covered only for pumps older than 48 months and if the pump cannot be repaired;
- Podiatric appliances for prevention of complications associated with diabetes.

DIAGNOSTIC SERVICES

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests. Covered Services include:

- Imaging services ordered by a Physician, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, SPEC scans and nuclear cardiac imaging;
- Diagnostic laboratory services ordered by a Physician.

DRUGS

Medically Necessary and Appropriate pharmaceuticals for the treatment of disease or injury. Covered Services include:

- Benefits for the treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician;
- Pharmaceuticals that are dispensed or intended for use while you are confined in a Hospital, skilled nursing facility or other similar facility.

The Plan includes coverage for Prescription Drugs.

You must purchase covered medications from a Network Pharmacy to receive Prescription Drug benefits. If you use a Non-Network Pharmacy, Prescription Drugs will not be covered.

OVER-THE-COUNTER MEDICATIONS

Over-the-counter medications are not a covered benefit, unless they appear on the Plan formulary.

MAINTENANCE DRUGS

If you take a medication on a regular or long-term basis, it may be considered a maintenance medication. You have the option to fill maintenance medications for up to a 90-day supply at either a local retail network pharmacy or at the Plan's approved mail order pharmacy. To find out if your medication is classified as a maintenance drug and eligible for a 90-day supply, please consult the formulary of medications available at www.chatn.org or contact the Customer Service number listed on your ID card.

SPECIALTY MEDICATIONS

Specific "specialty" medications may only be filled at the Plan's approved specialty pharmacy Provider to receive benefits. If these "specialty" medications are filled at a non-approved specialty pharmacy provider, they are not a covered benefit. To find out if your medication is classified as a "specialty" medication, please consult the formulary of medications available at www.chatn.org or contact Customer Service at the number listed on your ID card.

DURABLE MEDICAL EQUIPMENT

Medically Necessary and Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to you; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Physician for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for your convenience. Covered Services include:

- Rental of Durable Medical Equipment. Maximum allowable rental charge is not to exceed the total maximum allowable charge for purchase. If you rent the same type of equipment from multiple Durable Medical Equipment Providers and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, you will be responsible for amounts in excess of the maximum allowable charge for purchase;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Supplies and accessories necessary for the effective functioning of covered Durable Medical Equipment;
- The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is covered for pumps older than 48 months and only if the pump cannot be repaired.

FAMILY PLANNING AND REPRODUCTIVE SERVICES

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility. Covered Services include:

- Benefits for (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing;
- Sterilization procedures;
- Services or supplies for the evaluation of infertility;
- Injectable and implantable hormonal contraceptives and vaginal barrier methods

including initial fitting, insertion and removal.

HABILITATION SERVICES

Medically Necessary and Appropriate health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HOME HEALTH CARE SERVICES

Medically Necessary and Appropriate services and supplies provided in your home by a Provider who is primarily engaged in providing home health care services. Covered Services include:

- Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse;
- Home infusion therapy;
- Rehabilitative therapies such as physical therapy, occupational therapy, etc.;
- Medical social services;
- Dietary guidance.

HOSPICE

Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less. Covered Services include:

- Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

HOSPITAL EMERGENCY CARE SERVICES

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol. Covered Services include:

- Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of your Emergency condition;
- Physician services.

INPATIENT HOSPITAL SERVICES

Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24-hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility. Covered Services include:

- Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room);
- General nursing care;
- Medications;
- Injections;
- Diagnostic services;
- Special care units;
- Attending Physician's services for professional care;
- Maternity and delivery services (including routine nursery care and complications of pregnancy). If the hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits may be covered for the baby and mother as separate members, requiring payment of applicable member copayments and/or Deductibles.

ORGAN TRANSPLANTS

Medically Necessary and Appropriate services and supplies provided to you, when you are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in the Plan's discretion, are not Experimental or Investigational and that are Medically Necessary and Medically Appropriate. Covered Services include:

- Medically Necessary and Appropriate services and supplies at approved locations of service, otherwise covered under this EOC;
- Travel expenses for your evaluation prior to a covered procedure, and to and from the site of a covered procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for you and a companion. A companion must be your spouse, family member, or your guardian;
    - Travel by private care is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility.
    - Meals and lodging expenses, limited to $150 daily.
    - The aggregate limit for travel expenses is $10,000 per covered procedure.

- Donor organ procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from the donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of the transplant; and (5) donor follow-up care. Services are covered only to the extent not covered by other health coverage. The search process and securing the organ are also covered under this benefit. Complications of donor organ procurement are not covered. The cost of donor organ procurement is included in the total cost of your organ transplant.
- Use of Centers of Excellence for Transplant Procedures. The use of a Center of Excellence for transplant procedures **is required** to receive full benefits under the Plan. Call the Plan for complete information on transplant benefits and Centers of Excellence.

OUTPATIENT FACILITY SERVICES

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes: (1) outpatient Surgery centers; (2) the outpatient center of a Hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Physician's office. Covered Services include:

- Physician services;
- Outpatient diagnostics (such as x-rays and laboratory services);
- Outpatient treatments (such as medications and injections);
- Outpatient Surgery and supplies;
- Observation stays less than 24 hours.

PHYSICIAN'S OFFICE SERVICES

Medically Necessary and Appropriate services in a Physician's office. Covered Services include:

- Diagnosis and treatment of illness or injury. (Note that allergy skin testing is covered only in the Physician's office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is covered in the Physician's office setting and in a licensed laboratory);
- Injections and medications administered in a Physician's office, except Specialty Drugs. (See Provider Administered Specialty Drugs for information on coverage);
- Second surgical opinions given by a Physician who is not in the same medical group as the Physician who initially recommended the Surgery.

PROSTHETICS/ORTHOTICS

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery. Covered Services include:

- The initial purchase of surgically implanted prosthetic or orthotic devices;
- The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
- Splints and braces that are custom made or molded, and are incidental to a Physician's services or on a Physician's order;
- The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging;
- The initial purchase of artificial limbs or eyes;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Hearing aids for members under age 18, as limited herein.

PROVIDER ADMINISTERED SPECIALTY DRUGS

Medically Necessary and Appropriate Specialty Drugs will be covered under the Prescription benefits for the treatment of disease, administered by a Physician or home health care agency and listed as a Physician-administered drug on the Plan's Specialty Drug list. Covered Services include:

- Provider-administered Specialty Drugs, including administration by a qualified Physician.

RECONSTRUCTIVE SURGERY

Medically Necessary and Appropriate Surgical Procedures intended to restore normal form or function. Covered Services include:

- Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state;
- Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

SKILLED NURSING CARE

Medically Necessary and Appropriate Inpatient care provided to Members requiring medical rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care

rendered in a Hospital setting, or custodial or functional care rendered in a nursing home. Covered Services include:

- Room and board in a semi-private room;
- General nursing care;
- Medications;
- Diagnostics;
- Special care units;
- The attending Physician's services for professional care.

TELEPHONIC AND INTERACTIVE ELECTRONIC INTERCHANGES (E-VISITS)

Telephone Visits and e-visits between in network licensed Providers and members with documentation of clinical assessments and recommendations are eligible services.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)

Medically Necessary and Appropriate services to diagnose and treat Temporomandibular Joint Syndrome or Dysfunction (TMJ or TMD). Covered Services include:

- Diagnosis and management of TMJ or TMD;
- Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon;
- Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) oral appliances to stabilize the jaw joint.

THERAPEUTIC/REHABILITATIVE/ HABILITATIVE SERVICES

Medically Necessary and Appropriate therapeutic, habilitative and rehabilitative services performed in a Physician's office, outpatient facility or home health setting. Covered Services include:

- Outpatient, home health or office therapeutic, habilitative and rehabilitative services that are performed by, or under the direct supervision of a licensed therapist. Must have written authorization of the treating Physician;
- Therapeutic/Rehabilitative /Habilitative Services include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Physician's office, outpatient facility or home health setting. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits. Office visits for care other than actual therapy do not count towards those visit limits.

SUPPLIES

Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury. Covered Services include:

- Supplies for the treatment of disease or injury used in a Physician's office, outpatient facility or inpatient facility;
- Supplies for treatment of disease or injury that are prescribed by a Physician and cannot be obtained without a Physician's prescription.

VISION

- Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision. Covered Services include: Services and supplies for the diagnosis and treatment of diseases and injuries to the eye;
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery;
- Routine vision services for children under 18.

NOTIFICATION

To understand your costs for a scheduled inpatient admission or select outpatient procedures, you should call the Plan at the number listed on your Plan ID Card. For a complete list of procedures requiring notification, please visit www.chatn.org.

BENEFIT LIMITS AND EXCLUSIONS

Although the Plan covers most necessary medical expenses, there are some expenses that are not covered. This section outlines exclusions and limits of Your medical coverage. This list is not all-inclusive; if You have questions about a particular service or supply; contact the Plan at the telephone number appearing on the identification card.

USUAL AND CUSTOMARY

The Plan covers Covered Expenses up to the "usual and customary" amount when an Out-of-Network Provider or facility is used (except as otherwise stated herein). Usual and customary means the lesser of:

- the provider's usual charge for furnishing the service or supply, or
- the charge the claims administrator determines is reasonable based on the cost of providing the same or similar service or supply in the same geographical area.

Note: Covered Services rendered by an In-Network Provider will be paid at the Provider's negotiated rate as set forth in the network contract with Provider's network.

BENEFIT LIMITS

In addition to the exclusions listed below, refer to the *Schedule of Benefits* section in the Exhibit for the Maximum Individual Limit(s) and any Plan Year limit applicable to certain Covered Expenses. Plan Year limits are met by days/visits/dollar limits paid under all components of the Health Plan option in which You are enrolled. If You need additional information, contact the Plan at the telephone number appearing on the identification card.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan will not pay for or otherwise cover the cost of drugs or treatments considered Experimental and/or Investigational.

In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

EXCLUSIONS UNDER THE PLAN

No payment will be made under any benefit for expenses incurred in connection with the following, unless specifically stated otherwise in this document.

- Abortions, unless performed in order to save the life of the mother or if the fetus is not viable. Complications from an abortion performed to save the life of the mother are also covered.
- Amounts in excess of any Health Coverage limits.
- Any care connected with military service conditions for which an employee is legally entitled to service and for which facilities are reasonably accessible. This includes any charges incurred while on active duty with the armed services of any country or international organization.
- Adoption or surrogate expenses.
- Ambulance Services:
  - Transportation for Your convenience;
  - Transportation that is not essential to reduce the probability of harm to You;
  - Services when You are not transported to a Hospital.
- Any care not recommended and approved by a licensed Physician.
- Any charges of a Physician or health professional for services he or she provides to herself or himself or to any close relative. Close relative means spouse, domestic partner, brother,

sister, parent, grandparent or child and the spouse's or domestic partner's brothers, sisters, parents, grandparent or child.

- Any charges for treatment, services or supplies that are not Medically Necessary or usual for the treatment of an Illness or Injury as determined by the Plan's medical staff or an independent medical Physician review panel. This does not apply to qualifying preventive care services or other health care services specifically covered under the Plan that are not required to preserve Your health.
- Any dental care, treatment, implants, surgery, or supplies, except for the following:
  - repair started within 3 months of accidental injuries and completed within 12 months to sound natural teeth caused from being accidentally struck from outside the mouth and while covered under the Plan; or
  - inpatient hospital and anesthesia expenses related to dental work if the primary reason for such confinement (inpatient or outpatient) is deemed to be an underlying serious and hazardous medical condition.
- Any diagnostic admission to a facility if the test can be performed in a less restrictive or dangerous environment on an outpatient basis.
- Any Illness or Injury for which benefits or payments are received (or could be received if claims were made) under any workers' compensation law, employer's liability law or similar act.
- Any Illness or Injury for which any benefits are received or could be received if claims were made under any automobile insurance policy to the extent that the policy provides benefits for Covered Services under the Plan.
- Any treatment, equipment, drug or device that does not meet generally accepted standards of practice in the medical community supported in the peer reviewed medical literature.
- Arch supports, foot orthotics costing in excess of $500 or not prescribed by a medical doctor, and orthopedic shoes, such as biomechanical evaluation, range of motion measurements and reports, and negative mold foot impressions, unless the shoe is an integral part of a brace or when required following surgery or is a part of the initial care for treatment of a Medically Necessary condition.
- Augmentative communications devices.
- Autopsies.
- Balloon sinuplasty for treatment of chronic sinusitis.
- Behavioral health conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- Blepharoplasty, rhinoplasty, abdominoplasty, browplasty, or other cosmetic procedures.
- Charges for duplicating and obtaining medical records.
- Charges for or related to fetal tissue transplants.
- Charges related to organ transplants except as specified in the section entitled, *Organ Transplants*.
- Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is covered under this Plan.
- Charges for artificial organs or systems used to assist or replace a natural body organ (such as an artificial heart) and any related services or supplies. Note: Artificial support machines while awaiting a human organ or tissue transplant and other approved devices such as pacemakers and kidney dialysis machines are eligible.
- Charges for reconstructive surgery relating to aesthetic appearance and related services, except for the following:
  - reconstructive surgery and related charges following a covered mastectomy;
  - surgery to repair a defect caused by an accidental Injury resulting in a functional impairment;
  - reconstructive surgery related to an Injury, Sickness, or other disease of that part of the body;
  - reconstructive surgery following surgery that was needed due to an Injury, Sickness, or other disease of that part of the body;
  - cosmetic or reconstructive surgery or treatment to repair a Dependent child's congenital malformation or developmental defect.
- Charges for telephone calls with the office of a health professional for the failure to keep a scheduled visit, mailing, shipping and handling expenses, completing any form, for medical information, or other administrative services.

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- Charges for the treatment of compulsive gambling.
- Charges that exceed the allowed amounts and/or the Usual and Customary Charge.
- Charges in excess of the Maximum Allowable Charge for Covered Services.
- Charges for Gastric bypass, roux-en-Y, duodenal switch, sleeve gastrectomy, laparoscopic lap band. Additionally, any new or related procedures done for the purpose of weight reduction, elimination of obesity or the co-morbidities of obesity are also excluded.
- Charges for a drug, device, diagnostic or screening procedure, or a medical treatment or procedure of an Experimental or Investigative nature or an Unproven Service as determined by the Plan. This does **not** include drugs that: a) have been granted investigational new drug (IND) or Group C/treatment IND status; b) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or c) for which available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease as determined by the Plan. In the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information , or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan.
- Charges for handling fees.
- Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
- Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning.
- Cosmetic services, except as appropriate per medical policy. This exclusion applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to, Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins; (12) piercing ears or other body parts, (13) rhytidectomy or rhytidoplasty (surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculectomy/abdominoplasty; (16) thighplasty; (17) brachioplasty.
- Court ordered examinations and treatment, unless Medically Necessary.
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
- Custodial care or domiciliary care that includes services to assist in activities of daily living and personal care which do not seek to cure or do not need to be provided by a skilled medical professional.
- Dental Services:
  - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8)

tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;

  - Treatment for correction of underbite, overbite, and misalignment of the teeth including, but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth;
  - Extraction of impacted teeth, including wisdom teeth.

- Diabetes Treatment:
  - Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.
- Diagnostic Services:
  - Diagnostic services that are not Medically Necessary and Appropriate;
  - Diagnostic services not ordered by a licensed Practitioner.
- Durable Medical Equipment:
  - Charges exceeding the total cost of the maximum allowable charge to purchase the equipment;
  - Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
  - Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
  - Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
  - Items that require or are Dependent on alteration of home, workplace or transportation vehicle;
  - Motorized scooters, exercise equipment, hot tubs, pools and saunas;
  - "Deluxe" or "enhanced" equipment. Basic equipment that will provide the medically necessary intervention will determine the benefit;
  - Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs and seat lifts of any kind;
  - Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved as Medically Necessary;
  - Portable ramp for a wheelchair.
- Enteral feeding formulas, except for the following:
  - prescription and over the counter enteral feeding formulas when considered a sole source of nutrition and given via a feeding tube. This includes tube feeding supplies; or
  - oral prescription enteral formulas when considered a sole source of nutrition. Over the counter enteral feeding formulas are not covered when given orally.
- Expenses for care or treatment received outside the United States or its territories, except for unexpected, emergency situations while traveling or while on short or long-term international assignment.
- Expenses used to satisfy Plan Deductibles and/or coinsurance.
- Expenses eligible for consideration under any other Plan, including Medicare.
- Expenses not specifically listed as Covered Expenses under this Plan.
- Expenses incurred as a result of Your being drunk or under the influence of any controlled substance unless taken in accordance with the advice of a Physician for medically necessary care.
- Family Planning and Reproductive Services:
  - Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology; (6) fertility injections; (7) fertility drugs; (8) services for follow-up care related to infertility treatments;
  - Services or supplies for the reversals of sterilizations;
  - Sperm preservation;
  - Induced abortion unless: (1) the health care Provider certifies in writing that the pregnancy would endanger the life of the mother. y.
- Full body scans, EBCT (heart scans).
- Gene therapy as a treatment for inherited or acquired disorders.
- Homeopathic visits.
- Health services needed from attempting to commit or committing a felony, or

engaging in an illegal occupation.

- Health services performed before the effective date or after the termination of coverage under this Plan.
- Hearing aids for members age 18 or older.
- Home construction needed for the installation of special, Medically Necessary equipment.
- Home Health Care Services:
  - Items such as non-treatment services;
  - Routine transportation;
  - Homemaker or housekeeping services;
  - Behavioral counseling;
  - Supportive environmental equipment;
  - Maintenance care or custodial care;
  - Social casework;
  - Meal delivery;
  - Personal hygiene; and
  - Convenience items.
- Hospice Care:
  - Unapproved Inpatient services;
  - Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.
- Hospital Emergency Care Services:
  - Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
  - Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless prior authorization is obtained from the Plan within 24 hours or the next working day.
- Hypnosis or regressive hypnotic techniques.
- Inpatient Hospital Services:
  - Inpatient stays primarily for therapy (such as physical or occupational therapy) that can be safely and effectively provided in less restrictive and risky environments;
  - Services that could be provided in a less restrictive environment at less cost to Member and health Plan
  - Private room when not authorized by the Plan and room and board charges are in excess of semi-private room;
  - Blood or plasma that is provided at no charge to the patient.
- Illness or Injury resulting from war, that occurred before Your coverage began under this Plan and that is covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
- Lenses, frames and contact lenses; other fabricated optical devices or related professional services including the treatment of refractive errors such as radial keratotomy and laser refractive surgery regardless of medical condition, except when determined to be Medically Necessary following cataract surgery.
- Liposuction or Lipotherme.
- Marriage counseling.
- Maternity expenses for Dependents unless life threatening complications.
- Medical services or products purchased outside of the U.S., unless in an unexpected, emergency situation.
- Organ Transplants:
  - Services or supplies not specified as Covered Services;
  - Any attempted covered procedure that was not preformed, except where such failure is beyond Your control;
  - Non-Covered Services;
  - Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;
  - Any non-human, artificial or mechanical organ;
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
  - Any services which require prior authorization where such authorization is not received;
  - Removal of an organ from a Member for purposes of transplantation into another person, except as allowed by the Plan;

- Harvest, procurement and storage of stem cells, whether obtained from peripheral blood, cord blood or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis;
- Other non-organ transplants (e.g. cornea).

- Prescription drugs that have not been classified as effective by the FDA; bio-engineered drug therapy that has not received FDA approval for the specific use being requested; prescription drugs that are not administered according to generally accepted standards of practice in the medical community.
- Prosthetics or Orthotics:
  - Hearing aids for members age 18 or older;
  - Prosthetics primarily for cosmetic purposes, including, but not limited to: wigs, or other hair prosthesis or transplants;
  - Items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology;
  - The replacements of contacts after the initial pair have been provided following cataract surgery;
  - Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as part of a leg brace.
- Non-prescription drugs or medicines, except for those which appear on the formulary as a covered benefit and are prescribed by a licensed Practitioner.
- Non-emergency admissions greater than 24 hours in advance of procedure unless specified by Your Physician.
- Non-medical counseling or training services.
- Treatment by artificial means for the purpose of causing a pregnancy, such as but not limited to: prescription drugs, donor ova and sperm and artificial or intrauterine insemination procedures, assisted reproductive technology (ART) procedures, including, but not limited to, in vitro fertilization (IVF), gamete intracryopreservation or frozen embryo transfer.
- Outpatient Facility Services:
  - Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative benefit;
  - Services that could be provided in a less intensive setting.
- Personal comfort items while Hospitalized such as telephone or television; Hospital room and board expenses that exceed the semi-private room rate unless a private room is approved as Medically Necessary.
- Physician Office Services:
  - Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings;
  - Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) calluses; (4) toenails; (5) fallen arches; and (6) weak feet or chronic foot strain;
  - Rehabilitative therapies in excess of the limits of the Therapeutic/Rehabilitative benefit;
  - Dental procedures, except as otherwise indicated in this EOC.
- Physician charges for injections that can be self-administered.
- Phototherapy devices for Seasonal Affective Disorder.
- Private duty nursing services.
- Provider Administered Specialty Drugs:
  - Self-administered Special Drugs;
  - FDA-approved drugs used for purposes other than those approved by the FDA, except as provided herein.
- Reconstructive Surgery:
  - Services, supplies or prosthetics primarily to improve appearance;
  - Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service;
  - Surgeries and related services to change gender (transsexual surgery).
- Recreational or educational therapy or forms of non-medical self care or self-help training including health club memberships, weight loss programs, biofeedback, behavior modification therapy and any related services or diagnostic testing.
- Reversal of sterilization.
- Routine physical exams and immunizations for employment, travel or insurance purposes.

- Safety items, or items to affect performance primarily in sports-related activities.
- Sales tax.
- Self treatment or training.
- Services of the clergy.
- Services that are prohibited by law or regulations.
- Services or confinements ordered by a court or law enforcement officers that are determined not Medically Necessary (an initial court-ordered exam for a Dependent child under age 18 years is considered Medically Necessary).
- Services rendered by anyone other than a covered healthcare Provider. Services provided mainly for rest cures, the ease of a household, or sanitarium care.
- Services or supplies for common household use, such as exercise cycles, air purifiers, air conditioners, water purifiers, allergenic mattresses, computer equipment and related devices, or supplies of a similar nature, whether or not prescribed by a Physician.
- Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group.
- Services or supplies for Maintenance Care.
- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
- Services or supplies that are determined to be not Medically Necessary and Appropriate.
- Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
- Services for, or related to, systemic candidiasis, multiple chemical sensitivities, homeopathy, immunoaugmentative therapy or chelation therapy determined to be not Medically Necessary.
- Services, supplies, chemotherapy, drugs and aftercare for or related to an organ, tissue, or bone marrow transplant or stem cell transplant that is not covered.
- Services related to mental retardation.
- Services that are free.
- Skilled Nursing/Rehabilitative Facility Services:
  - Custodial, domiciliary or private duty nursing services;
  - Skilled nursing services not received in a Medicare certified skilled nursing facility;
  - Services for cognitive rehabilitation.
- Sleep disorders.
- Staff consultations required by hospital or other facility rules.
- Supplies that can be obtained without a prescription (except for diabetic supplies).
- Temporomandibular Joint Dysfunction (TMJ) – The following services sometimes associated with TMJ are not covered under the Plan's medical benefits:
  - Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth;
  - Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.
- Therapeutic/Rehabilitative Services:
  - Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
  - Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) cognitive rehabilitation; (5) vision exercise therapy; and (6) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes

performed as part of a physical therapy visit;

- Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver;
- Behavioral therapy, play therapy, communication therapy, and therapy for self correction language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
- Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

- Travel and/or lodging expenses of a Physician or a patient, except as specified in the Organ Transplant section.
- Treatment for benign gynecomastia.
- Treatment for hyperhidrosis.
- Treatment while confined in a state, federal or Veterans Administration Hospital for which charges are not imposed.
- Transportation other than local ambulance service for a medical emergency to the nearest Hospital that can provide care. Air ambulance covered if only reasonable means of transport available.
- Vagus nerve stimulation for the treatment of depression.
- Vision:
  - Routine vision services for adults over age 19, including services, surgeries and supplies to detect or correct refractive errors of the eyes;
  - Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
  - Eye exercises and/or therapy;
  - Visual training.
- Vocational and educational training services except approved diabetic education programs, cardiac rehabilitation, pre-term birth prevention for high risk pregnancies, asthma, or cancer programs.

DESCRIPTION OF IN-NETWORK AND OUT-OF-NETWORK UNDER THE HEALTH PLAN

This section includes information about how In-Network and Out-of-Network Benefits work and how emergency health services are covered.

IN-NETWORK BENEFITS

In-Network benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are payable for Covered Expenses which are:

- Provided by a Network Physician or other Network Provider, or
- Considered to be an Out-of-Network Benefit exception.

Payment for In-Network Benefits are based on the Network Provider's negotiated rate as established by the Provider's Network. Network Providers have agreed not to Balance Bill you for the difference between their charges and what the Plan pays.

PROVIDER NETWORK

The Plan arranges for health care providers to participate in a Network. Network providers are not our employees or employees of the Plan. It is Your responsibility to select Your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services, You should always verify the network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when You are referred by another Network Provider. You can verify the provider's status by calling Your Plan at the number on Your ID card.

It is possible that You might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or, You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network provider to get Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Expenses. Some Network providers agree to provide only certain Covered Expenses, but not all Covered Expenses. Some Network providers choose to be a Network provider for only some products. You may contact the Plan at the number on Your ID card for assistance in choosing a provider or with questions about a particular provider's Network participation.

OTHER PROVIDERS

If You have a medical condition that the Plan believes needs special services, they may direct You to a provider chosen by them. If You require certain complex Covered Services for which expertise is limited, the Plan may direct You to an Out-of-Network Provider.

In both cases, Benefits will only be paid if Your Covered Expenses for that condition are provided by or arranged by the other provider chosen by the Plan.

OUT-OF-NETWORK BENEFITS

Out-of-Network Benefits are generally paid at a lower level than Network Benefits. Out-of-Network Benefits are payable for Covered Expenses that are provided by Out-of-Network Providers.

WHAT IF I'M TRAVELING AND NEED MEDICAL CARE?

If you are traveling outside your network and you need medical care, you should contact Customer Service at the telephone number appearing on the identification card or log onto www.chatn.org for assistance is locating the nearest network Provider. If you need Emergency Care, however, go ahead and get the care you need.

EMERGENCY CARE

The Plan provides Benefits for Emergency Care when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

In-Network Benefits are paid for Emergency Care, even if the services are provided by an Out-of-Network Provider.

CONFINEMENT IN AN OUT-OF-NETWORK HOSPITAL FOLLOWING AN EMERGENCY

If You are confined in an Out-of-Network Hospital after You receive Emergency Health Services, the **Plan must be notified within two (2) business days or on the same day of admission if reasonably possible.** The Plan may elect to transfer You to a Network Hospital as soon as it is

medically appropriate to do so. If You choose to stay in the Out-of-Network Hospital after the date the Plan decides a transfer is medically appropriate, Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Service.

OTHER EXCEPTIONS

If, while an Inpatient or receiving Outpatient services, You have an x-ray, receive laboratory services, or anesthesia services from an Out-of-Network Provider while You are in an In-Network facility, we will cover the service at the In-Network benefit level.

CLAIMS PROCEDURES UNDER THE HEALTH PLAN

Claims are processed according to the benefits of the Plan You selected. Please review Your Schedule of Benefits for further information on Your Plan. You can also visit our website at www.chatn.org or call the Customer Service department for further details on Your Plan selection.

HOW CLAIMS ARE PROCESSED

When You receive care from Your health care Provider, You will present Your ID card. Your Provider should submit a claim for payment directly to the Plan. This amount will be applied to the Plan option in which You've enrolled. If Your Provider does not file a claim on Your behalf, follow the procedures below, under *Submitting a Claim*.

SUBMITTING A CLAIM

At time You may be responsible for submitting a claim directly to the Plan. All claims should be mailed to the Plan. You may download claim forms from our web site through our Member portal at www.chatn.org or by calling the Customer Service number on Your ID card if You are unable to print a claim form.

For information on how to file a claim for pharmacy benefits, contact Customer Service.

You must submit Your claims to the Plan within 15 months of the date of service. Benefits for Your service can be denied or reduced, at the Plan's discretion, if not received timely.

REQUIRED INFORMATION

Please be prepared to provide the following information when submitting Your claim form:

- Your name, date of birth and address;
- The patient's name, if different from the policyholder, date of birth and family relationship to You;
- The Member number stated on Your ID card; and
- An itemized bill from Your Provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure Code(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - The Provider's Name, Address and Tax Identification Number.

Note: When submitting Your claim for reimbursement, You must also include a receipt showing proof of payment.

Submit Your claims to the address appearing on Your ID card.

PROVIDING AUTHORIZATION

In Your application, You have agreed that Your Provider may provide the Plan with the needed information about the care they provide to You. The Plan keeps all such information strictly confidential. If a Provider requires specific authorization to release records, You agree to provide this authorization. Your failure to provide authorization or requested information may result in denial of Your claim.

CLAIMS PAYMENTS

Payments will be made directly to the Providers who have submitted a claim to the Plan on Your behalf.

Payments for manually submitted claims or Out-of-Network claims will be made to You unless either of the following is true:

- The Provider notifies the Plan that it has Your signature on file, assigning benefits directly to that Provider.; or
- You make a written request for the Out-of-Network Provider to be paid directly at the time You submit Your claim.

When Your claims are processed for payment, You will receive a notice of the action taken by the Plan in the form of an Explanation of Benefits or EOB. The EOB provides the details of how the claim was processed. For example; it will show how much the Plan paid Your Provider, the procedures performed, the date the service was performed, and the amount of money You may owe the Provider, if any.

The EOB will also show if the Plan did not process or pay Your claim. In some cases, additional information may be needed or is requested to complete claim payment; or the claim may be denied payment by the Plan. The EOB will state the specific reason or reasons for the denial, refer to specific Plan provisions on which the denial is based, contain a description of any information necessary for the claim to be processed and an explanation of why such information is necessary. The EOB will also tell You how to file a formal Appeal and the time limits for filing an Appeal, including Your right to bring a civil action following an adverse

determination upon Appeal. If the denial is based on medical necessity or experimental treatment, the denial notice will contain information on the scientific or clinical judgment for the denial, applying the terms of the Plan to Your medical circumstances. The denial notice will also contain information about the internal rule, guideline or protocol that was relied on, if applicable.

QUESTIONS AND APPEALS

This section provides You with the information to help You with the following:

- You have a question or concern about the Covered Health Service or Your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and You wish to Appeal such determination.

Nothing prevents You from filing a complaint with the Tennessee Department of Commerce and Insurance; however, such complaints are separate from, and in addition to, the Appeals processes in this EOC.

To resolve a question or file an Appeal, just follow these steps:

WHAT TO DO FIRST

If Your question or concern is about a benefit determination please contact Customer Service before requesting a formal Appeal. The Plan has staff that is dedicated to resolving customer concerns. If we are unable to resolve the issue, please review and follow the instructions listed in the next section, *How to File an Appeal*.

Customer Service representatives are available to take Your call during regular business hours, Monday through Friday from 8am to 6pm.

HOW TO FILE AN APPEAL

If You disagree with a benefit determination after following the above steps, You may contact Customer Service in writing or over the phone to formally request an Appeal. Your request should include:

- The patient's name and the identification number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason You believe the claim should be paid; and
- Any documentation or other written information to support Your request for claim payment.

Your first Appeal request must be submitted to the Plan within 180 days after You receive notification of the benefit determination that You disagree with.

APPEAL PROCESS

A qualified individual who was not involved in the decision being Appealed will be appointed to decide the Appeal. If Your Appeal is related to clinical matters, the review will be done with a health care professional with expertise in the field who was not involved in the prior determination. The Plan consults medical experts as part of the Appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge, You have the right to reasonable access to and copies of, all documents, records, and other information relevant to Your claim for benefits.

APPEALS DETERMINATIONS

You will be provided written or electronic notification of the decision on Your Appeal. You have two levels of Appeals.

- The first level Appeal will be conducted and You will be notified of the decision within a reasonable time given Your medical condition, but not later than 30 days from receipt of Your request. Prior to the first level decision and within 5 days of receipt of the first level Appeal, You will be notified of Your right to submit written documents, records and other materials relating to the request for benefits as well as have access to, and copies of all documents, records and other information, free of charge, which are relevant to Your request for benefits.

  The second level Appeal will be conducted by a review panel of qualified individuals the majority of whom were not involved in the first level Appeals decision. They will have the appropriate expertise or have access to the appropriate expertise regarding the subject of the second level Appeal under review.

- Within 5 days of Your request for a second level Appeal, You will be notified of Your right to:
  - Request, within a reasonable amount of time, the opportunity to appear in person before a review panel of designated representatives;
  - Receive, upon request, copies of all documents, records, and other information that is not confidential or privileged with regard to Your request for benefits;
  - Present Your case to the review panel;
  - Submit written comments, documents and records for the review panel to consider;

- If applicable, to ask questions of any representatives on the review panel; and
- Be assisted or represented by an individual of Your choice, at Your own expense.

You will be notified by the Plan Administrator of the decision on Your second level Appeal within 30 days from the receipt of Your request for a review of the first level Appeal decision.

- For urgent procedures, see *Urgent Appeals that Require Immediate Action* below.

If Your Appeal is denied, You will receive a notice explaining: the reason for the denial; specific references to the part of the Plan on which the denial is based; a statement that You are entitled by law to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; a statement regarding any voluntary Appeal procedures offered by the Plan and Your right to bring a civil action after an Adverse Determination; on Appeal; information about the internal rule, guideline or protocol that was relied on, if applicable; and information on the scientific or clinical judgment for the determination if the adverse decision is based on Medical Necessity or experimental treatment.

URGENT APPEALS THAT REQUIRE IMMEDIATE ACTION

Your Appeal may require immediate action if it involves an adverse decision about admission, availability of care, continued stay, or healthcare services when You have received Emergency services but have not yet been discharged. In these urgent situations:

- The Appeal does not need to be submitted in writing. You or Your Physician may request an expedited internal Appeal orally or electronically.
- You will be provided with all documents and information being considered in the expedited Appeal by phone, email, fax, or other reasonable means.
- The Plan will provide You with a determination as expeditiously as Your condition requires, but not more than 72 hours following the receipt by the Plan of Your urgent Appeal request by the Plan.
- You can pursue an Expedited External Review while simultaneously pursuing an Expedited (Urgent) Internal Appeal.

STANDARD EXTERNAL REVIEW

You may request a standard external review if:

- You have exhausted the internal review processes documented above under *Appeal Determinations*; or
- The Plan has not provided You with a determination on Your internal Appeal within the applicable time frame; and
- The request for external review is received within 6 months of the final internal Adverse Determination.

External review is available if the decision to deny benefits is based on one of the following:

- Lack of Medical Necessity
- Failure to meet requirements with regard to appropriateness, setting, level of care, or effectiveness; or
- The exclusion for Experimental, investigational or Unproven services or treatment and Your condition is life threatening or seriously disabling; and
- A rescission of coverage

The Plan will notify You, within 3 business days of Your request for external review, whether Your request is eligible for external review. The Plan will also instruct You on how to submit additional documentation for Your Appeal

If Your Appeal is eligible for external review, the Plan will send Your request to an Independent Review Organization (IRO) at the Plan's expense. A decision will be made on Your external review within 45 days from the date of Your request.

The IRO's decision will be binding and no subsequent review will be available.

EXPEDITED EXTERNAL REVIEW

You may request an expedited external review if:

- The denial involves a medical condition where the time frame for a standard external review would seriously jeopardize Your life, health or ability to regain maximum function; or
- The denial was based upon a determination concerning an admission, availability of care, continued stay, or health care service for which You received emergency care and have not been discharged from a Facility.

If Your Appeal is not eligible for an expedited external review, You will be notified in writing.

If Your Appeal is eligible for an expedited external review, the Plan will immediately send Your request to an IRO at the Plan's expense.

A decision will be made on Your expedited external review as quickly as Your medical condition or circumstances require, but no more

than 72 hours from the time of Your request.

The decision made by the IRO will be binding and no subsequent review will be available.

EXAMINATION AND AUTOPSY

The Plan, at its own expense, may examine the person l for whom a claim is made as often as reasonably necessary while a claim is pending, and in cases of death of the Member, may have an autopsy performed during the period of contestability and unless prohibited by law.

COORDINATION OF BENEFITS AND SUBROGATION

If You have health care coverage through another employer, this section is for You. For example, You may be covered as a Dependent under Your spouse's medical Plan. This "coordination of benefits" provision prevents duplicating benefit payments when You or Your Dependent(s) also have coverage through another group Plan. Coordination of benefits also determines which Plan pays first.

HOW COORDINATION OF BENEFITS WORKS

Covered expenses not reimbursed by the primary Plan (see below) will coordinate with Your Plan for payment.

Here's how coordination of benefits works: The first step is to determine which Plan is primary and which Plan is secondary. The primary Plan always pays benefits first. When the Plan is secondary, benefits are coordinated so that the total benefits from all the Plans are no more than the maximum allowed by the Plan.

AN EXAMPLE

Assume your spouse is covered under his or her own employer's Plan and as your dependent under the Plan, and incurs a $100 expense for an office visit.

Let's also assume the Plan considers the allowable expense for the office visit is the full $100.

If your spouse's Plan covers the visit at 80% ($80), the Plan will pay $20 ($100 - $80).

In this example you would be reimbursed a total of $100 ($80 + $20).

ORDER OF COVERAGE—EMPLOYEE AND SPOUSE

- If one of the Plans does not have a coordination of benefits provision, that Plan will pay first.
- If You (or Your spouse) are covered as an employee, member or subscriber by one Plan and as a Dependent by another, the Plan that covers the person as employee, member or subscriber will pay benefits first. If You or Your spouse are also covered by Medicare and are not working:
  - the Plan that covers a person as a Dependent of an employee is primary,
  - Medicare is secondary, and
  - the Plan that covers a person as an employee, member or subscriber pays third.
- If You or Your spouse is covered as an employee and also as a retired or laid off employee (one of them through another employer) the Plan that covers the person as an employee (or a Dependent of an employee) is primary.

ORDER OF COVERAGE—DEPENDENT CHILDREN

For a Covered Dependent child whose parents are not divorced or separated and who is covered as a Dependent under both parents' Plans:

- The Plan of the parent whose birthday is first in a calendar year will pay benefits first for the covered child. For example, if the father's birthday is in March and the mother's birthday is in September, the father's Plan is primary for the child. This is called the "birthday rule."
- If the parents have the same birthday, the Plan that has covered a parent longer will pay benefits first for the child. For example, if the father has had coverage under his Plan for five years and the mother has had coverage under her Plan for seven years, the mother's Plan is primary for the child.
- If the other Plan does not use the birthday rule but bases the order of benefits on the gender of the parent so that the Plans don't agree on order, the rules of the other Plan will determine which Plan pays first.

If two or more medical Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined as follows:

If under a court decree the parents have joint custody but the decree doesn't state who is responsible for the child's health care expenses, benefits will be coordinated the same as for the children of married parents.

- The medical Plan of the parent who has a court decree of financial responsibility will be primary.
- If no court decree exists, and
  - the parent with custody has not remarried; the medical Plan of the custodial parent will be primary.
  - the parent with custody has remarried:
    - the Plan of the custodial parent will be primary,
    - the Plan of the stepparent will be secondary, and
    - the Plan of the non-custodial parent will be third.

COORDINATION WITH MEDICARE

If You keep working for Your current employer and You or a Covered Dependent becomes eligible for Medicare, the Plan will remain Your primary Plan and Medicare will be secondary.

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If You are eligible for or enrolled in Medicare, please read the following information carefully. If You are eligible for Medicare on a primary basis (Medicare pays before benefits under the Plan), You should enroll for and maintain coverage under both Medicare Part A and Part B. If You don't enroll and maintain that coverage, and if the Plan is the secondary payer, the Plan will pay benefits under the Plan as if You were covered under both Medicare Part A and Part B. As a result You will be responsible for the costs that Medicare would have paid and You will incur a larger out-of-pocket cost.

OTHER COORDINATION RULES

If none of the above rules determines the order of benefits, the benefits of the Plan that has covered an employee, member or subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

The start of the new Plan does not include: a change in amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another.

The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under the Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

Some Plans declare their coverage "in excess" to all other Plans, "always secondary," or otherwise not governed by COB rules. These Plans are "non-complying Plans." This Plan coordinates with non-complying Plans as follows: if this Plan is the primary Plan, it will provide its benefits on a primary basis; if this Plan is the secondary Plan, it will provide benefits first, but the amount of benefits and liability of this Plan will be limited to the benefits of a secondary Plan. If the non-complying Plan does not provide information needed to determine this Plan's benefits within a reasonable time after it's requested, this Plan will assume that the benefits of the non-complying Plan are the same as the benefits of this Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan. If the non-complying Plan reduces its benefits so that the employee, member or subscriber receives less in benefits than he or she would have received had the complying Plan paid, or provided its benefits as the secondary Plan, and the non-complying Plan paid or provided its benefits as the primary Plan; and governing state law allows the right of subrogation, then the complying Plan shall advance to You, or on Your behalf, an amount equal to such difference. However, in no event shall the complying Plan advance more than the complying Plan would have paid, had it been the primary Plan, less any amount it previously paid. In consideration of such advance, the complying Plan shall be subrogated to all Your rights against the non-complying Plan. Such advance by the complying Plan shall also be without prejudice it may have against the non-complying Plan in the absence of such subrogation.

SUBROGATION AND THIRD PARTY RECOVERY

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment

made by this Plan for health care benefits that is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

RIGHT OF REIMBURSEMENT AND RECOVERY

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical benefits and expenses which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

The Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies specifically designated as medical expenses and that: (1) is paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of the Plan pays medical benefits and expenses and the Plan is the primary issuer. ("Subrogated Amount").. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pay and Pursue."** The Plan has elected the "pay and pursue" option in connection with the subrogation, reimbursement and equitable lien rights for claims involving Covered Services. Pursuant to the election of "pay and pursue," benefit payments will be made prior to applying the subrogation, reimbursement and equitable lien rights under the Plan.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any medical benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:
   a. Any no-fault insurance;
   b. Medical benefits coverage under any automobile liability Plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
   c. Under-insured and uninsured motorist coverage;
   d. Any automobile medical payments and personal injury protection benefits;
   e. Any third party's liability insurance
   f. Any premises/guest medical payments coverage;
   g. Any medical malpractice recovery;
   h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of

employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.

i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

4. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

5. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.

6. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

CONTINUATION OF COVERAGE

COBRA CONTINUATION COVERAGE

This section generally explains COBRA Coverage, when it may become available to You or Your family, and what You need to do to protect the right to receive it.

COBRA Coverage is only available as required by law. Contact the Plan to find out if COBRA is available to You.

OVERVIEW

You and Your Covered Dependents have the option to purchase temporary continuation coverage in certain instances when coverage would otherwise end. This is called COBRA coverage. The right to COBRA Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA coverage for the Plan is administered by:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below and in the table to the right. After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse, and Your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay for COBRA Coverage. If You elect COBRA Coverage, the coverage will be identical to the coverage provided under the Plan to similarly situated employees or their family members at the time coverage is being provided to You.

QUALIFYING EVENTS FOR EMPLOYEES, SPOUSES AND DEPENDENT CHILDREN

If You are an employee, You will become a qualified beneficiary and have a right to choose COBRA Coverage if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary and have a right to choose COBRA Coverage if You lose Your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both) and loses coverage under the Plan due to the Medicare entitlement; or
- You and Your spouse become divorced or legally separated.

Your Dependent children will become qualified beneficiaries and have a right to choose COBRA Coverage if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent (employee) dies;
- The parent (employee)'s hours of employment are reduced;
- The parent (employee)'s employment ends for any reason other than his or her gross misconduct;

	Maximum COBRA Coverage Period		
Qualifying Event	Employee	Spouse	Dependent Child
Termination of employment (other than for gross misconduct)	18 months	18 months	18 months
Reduction in hours (below hours necessary to meet eligibility requirements)	18 months*	18 months*	18 months*
Employee enrolls in Medicare (as second qualifying event)	N/A	36 months	36 months
Divorce or legal separation	N/A	36 months	36 months
Death of employee	N/A	36 months	36 months
Child ceases to be a dependent child	N/A	N/A	36 months

* 24 months if the reduction in hours results from taking military leave.

- The parent (employee) becomes entitled to Medicare benefits (Part A, Part B, or both) and loses coverage under the Plan due to Medicare entitlement;
- The parents divorce or legally separate;
- The child stops being eligible for coverage under the Plan as a Dependent Child.

In general, a domestic partner (and eligible children of a domestic partner) who lose coverage under the Health Plan are not eligible for COBRA coverage. However, if You lose coverage due to Your termination of employment or reduction in hours and You elect COBRA coverage for Yourself, Your domestic partner (and eligible children of Your domestic partner) will be permitted to elect continued coverage that is similar to COBRA coverage. Contact Customer Service for details.

THE PLAN'S NOTIFICATION REQUIREMENTS

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. When one of the qualifying events occurs, the Plan will notify You of Your rights to choose COBRA Coverage:

- When the qualifying event is the end of employment or reduction of hours of employment;
- When the qualifying event is the death of the employee; or
- When the qualifying event is Medicare (Part A, Part B, or both) entitlement resulting in loss of coverage.

Note: Notices are sent to You at Your last address on file with the Plan Administrator.

YOUR NOTIFICATION REQUIREMENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan. The Plan requires written notification within sixty (60) days after the qualifying event occurs. You must send this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

Your failure to provide notice as required within 60 days will result in a denial of Your request for COBRA Coverage and Your group health coverage will end. Not choosing COBRA Coverage may cause a break in Your group health coverage, and any such break of more than sixty-three (63) days may cause loss of coverage portability.

HOW TO ELECT COBRA CONTINUATION

Once the Plan receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Coverage. Covered employees may elect COBRA Coverage on behalf of their children. Your election notice must be sent within sixty (60) days following the date coverage under the Plan ends or the date You receive notice of Your rights to COBRA Coverage, whichever date is later.

It is important to note that Your failure to make a COBRA election within the time periods required under COBRA will result in a denial of Your request for COBRA Coverage.

If You or Your Covered Dependent chooses COBRA Coverage, You must advise the Plan of Your choice in writing. The Plan may be contacted at:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WHAT ARE YOUR COBRA CONTINUATION PERIODS?

COBRA Coverage is a temporary continuation of coverage.

COBRA coverage can last for up to 36 months when Plan coverage is lost due to:

- the death of the employee,
- the covered employee's divorce or legal separation, or
- a Dependent child's losing eligibility as a Dependent child.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the Covered Person becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours.

COBRA coverage generally can last for only up to a total of eighteen (18) months when Plan coverage is lost due to:

- the end of employment ,or
- reduction of the employee's hours of employment.

EXTENSION OF 18-MONTH CONTINUATION COVERAGE

There are two ways in which this 18-month period of COBRA Coverage can be extended: (1) if a qualified beneficiary is disabled; or (2) a secondary qualifying event occurs.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan becomes a qualified beneficiary is determined by the Social Security Administration to be disabled and You make notification in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA Coverage, for a total maximum of twenty-nine (29) months. The disability must start some time before the 60th day of COBRA Coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual must submit proof of the determination of disability by the Social Security Administration within the initial eighteen (18) month COBRA Coverage period and within sixty (60) days after the latest of (i) the date of the Social Security Administration's disability determination, (ii) the date on which the qualifying event occurs, or (iii) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the qualifying event.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that the person make notification within thirty (30) days of such determination. The notices with regard to disability should specify the name of the Plan, the name of the employee covered by the Plan and the disability determination of which You are giving notice. You must provide this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

If Your family has another qualifying event while receiving 18 months of COBRA Coverage, the qualified beneficiaries in Your family can get up to eighteen (18) additional months of COBRA Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and Dependent children receiving continuation coverage if:

- The employee or former employee dies;
- The employee or former employee and spouse get divorced or legally separated; or
- If the Dependent child stops being eligible under the Plan as a Dependent child.

This extension will be made available only if the individual is a qualifying beneficiary and the event would have caused the spouse or Dependent to lose coverage under the Plan had the first qualifying event not occurred.

The Covered Employee's entitlement to Medicare benefits may also be a second qualifying event that will allow a qualified beneficiary in the covered employee's family to receive up to an additional eighteen (18) months of continuation coverage. This extension is only available if the Medicare entitlement would have resulted in loss of coverage under the Plan had the first qualifying event not occurred. Medicare entitlement normally does not result in a loss of coverage under the Plan; therefore, a second qualifying event extension due to Medicare entitlement will only be available under limited circumstances.

If the subsequent qualifying event is Your divorce or legal separation, Your child's loss of Dependent status or Your entitlement to Medicare, You or Your Dependent must make notification in writing of that event within sixty (60) days of the qualifying event. The notice should specify the name of the Plan, the name of the employee covered by the Plan and the qualifying event of which You are giving notice. You must provide this notice to:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

PAYMENT FOR COBRA CONTINUATION COVERAGE

Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay the entire cost for COBRA Coverage, plus an administration fee of up to two percent (2%). The initial payment must be made within forty-five (45) days after the date You notify the Plan that You have chosen to continue coverage. The initial payment is the amount needed to pay for coverage from the date Your continued benefits begin through the last day of the month in which the initial payment is made. Thereafter, payments for COBRA Coverage must be made monthly and must be remitted on or before the first day of each month during the continuation period. However,

if the monthly Premium payment is less than the required amount by no more than the lesser of $50 or 10% of the required amount, then the person paying the Premium will be notified and given thirty (30) days to pay the additional amount.

COBRA TERMINATING EVENTS

COBRA provides that COBRA Coverage may be cut short for any of the following reasons:

The employer no longer provides group health coverage to any of its employees;

- The Premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered under another group health Plan;
- The qualified beneficiary becomes entitled to Medicare; or
- The qualified beneficiary extends coverage for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. Contact the Plan changes of address. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator or HSB.

IF YOU HAVE COBRA QUESTIONS

If You have questions about Your COBRA Coverage, You should contact:

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

Or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

STATE CONTINUATION AND CONVERSION COVERAGE

STATE CONTINATUION COVERAGE OVERVIEW

If the Group Agreement remains in effect, but Your coverage under this EOC would otherwise terminate, the Group may offer You the right to continue coverage for a limited period of time according to State law. If You are eligible for COBRA Coverage, You may elect either COBRA Coverage or State Continuation Coverage, but not both.

ELIGIBILITY

You are eligible if You have been continuously covered under this Plan, or a health Plan that this Plan replaced, for at least 6 months prior to the date of termination of Your coverage under the Group Agreement, for any reason except for nonpayment of required contribution.

You are not eligible if: You were entitled under Federal law to continuation coverage for a period greater than what is provided in this section; You are eligible for other group coverage that provides benefits similar to this Plan; or if You are eligible for Medicare benefits.

ENROLLING FOR STATE CONTINUATION COVERAGE

The group will notify Members eligible for State Continuation Coverage about how to enroll for such coverage on or before the date their coverage would otherwise terminate under the Group Agreement. You must request State Continuation Coverage, in writing, and pay the Premium for that coverage, in advance, as required by the Group.

PREMIUM PAYMENT

You must pay the monthly Premium for State Continuation Coverage to the Group at the time and place specified by the Group.

SECONDARY COVERAGE

Any benefits, except extended benefits payable by the Plan during the period of continuation, are considered secondary to benefits under any other group health Plan that is in force on You during this continuation period.

COVERAGE PROVIDED

Members enrolled for State Continuation Coverage will continue to be covered under the Group Agreement and this EOC, for the rest of the month during which coverage under the Group Agreement would end and 6 additional months.

TERMINATION OF STATE CONTINUATION COVERAGE

State Continuation Coverage will terminate upon the earliest of the following: the end of the applicable period specified above; the end of the period for which You paid the Premium for coverage; or the termination date of the Group Agreement; or the date You become eligible for coverage under another group health benefits Plan; or the date You become entitled to Medicare coverage.

CONVERSION COVERAGE

If Your coverage under this Plan terminates for any reason other than: You fail to pay a required Premium; You become eligible for Medicare; or the Group Agreement is replaced by similar group coverage within 31 days; You may be eligible for conversion to Individual coverage. This provision does not continue coverage under the Group Agreement. Conversion coverage is individual health care coverage from the Plan. Conversion coverage shall be:

- The type of individual coverage offered to converting members as of the date of the termination of their coverage under the Group Agreement;
- Issued without evidence of insurability; and
- Effective as of the date of the termination of Your group coverage. The Plan shall provide an enrollment form and information about that conversion coverage upon written request from You. You must submit a completed enrollment form and the Premium for conversion coverage to the Plan, within 31 days after the termination of Your coverage under the Group Agreement.

GENERAL INFORMATION

GENERAL INFORMATION

CREDITABLE COVERAGE UNDER HIPAA

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Your employer must issue a "certificate of creditable coverage", in writing, free of charge:

- when You lose coverage under the Plan;
- when You become entitled to elect COBRA;
- when Your COBRA coverage ends;
- if You request a certificate of credible coverage before losing coverage; or
- if You request a certificate of credible coverage up to twenty-four (24) months after losing coverage.

"Creditable Coverage" means health care coverage under any of the types of Plans listed below, during which there was no break in coverage of sixty-three (63) consecutive days or more:

- a group health Plan;
- health insurance coverage;
- Medicare;
- Medicaid;
- medical and dental care for members and certain former members of the uniformed services, and for their Dependents;
- a medical care program of the Indian Health Services Program or a tribal organization;
- a state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- The State Children's Health Insurance Program (S-CHIP);
- health Plans established and maintained by foreign governments or political subdivisions and by the U.S. government;
- any health coverage provided by a governmental entity;
- any public health benefit program provided by a state, county, or other political subdivision of a state; or
- a health benefit Plan under the Peace Corps Act.

If You or Your Eligible Dependents were covered by any of the above Plans before first becoming covered by this Plan, You should have received a Certificate of Creditable Coverage when that Plan's coverage ended.

You may request a certificate of creditable coverage under this Plan by contacting the Plan at the number on Your ID card.

PRIVACY NOTICE FOR THE PLAN

The Privacy Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the notice carefully.

HIPAA PRIVACY NOTICE

This Privacy Notice describes how the Plan may use and disclose Your health information to carry out treatment, payment and health care operations and for other uses and disclosures that are required or permitted by law. If You receive benefits under the Health Plan, this Privacy Notice explains the rights You have with respect to Your health information, and certain obligations the Health Plan must abide by in accordance with the law.

The Health Plan is required by law to maintain the privacy of Your health information and to provide You with this Privacy Notice outlining its legal duties and privacy practices with respect to Your health information. Nothing contained in this Privacy Notice should be construed to supersede or limit any additional rights You may be entitled to under other applicable law. Therefore, if an applicable law affords You greater rights or more protections, the Health Plan will comply with the law that gives You greater rights and/or protections.

The Health Plan is required to abide by the terms of this Privacy Notice, but reserves the right to make additional changes to this Privacy Notice and to make such changes applicable to all of Your health information that it maintains. If the Health Plan makes any material revisions to this Privacy Notice, it will provide You with a copy of the revised Privacy Notice which will specify the date on which such revised Privacy Notice becomes effective.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

The Health Plan may use Your health information for treatment, payment and health care operations. The Health Plan may also use Your health information for other purposes that are permitted and/or required by law and pursuant to Your written authorization.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the Health Plan will be required to limit its distribution, use or requests

for protected health information, to the extent practicable, to a limited data set, or if more information is needed, to the minimum necessary amount of information needed to accomplish the intended purpose of the data use. The Secretary of HHS shall issue guidance on what constitutes minimum necessary for the purposes of this provision no later than 18 months following the enactment date. The enactment date is February 17, 2009.

The following lists examples of how the Health Plan may use and/or disclose Your health information. Any other uses or disclosures not described in this Privacy Notice will only be made with Your explicit written authorization, which authorization You may revoke at any time by providing the Health Plan with written notice of Your revocation.

A. For Treatment.
The Health Plan may disclose Your health information to a health care provider that provides treatment to You. For example, in an emergency situation, the Health Plan may provide Your health care provider with information regarding the type of prescription drugs You are currently taking if necessary for Your proper treatment.

B. For Payment.
The Health Plan may use Your health information to obtain Premium payments or to fulfill its responsibility for coverage and the provision of benefits under the Health Plan. For example, the Health Plan may receive and maintain information about a health care service You received in order to process a claim from a physician for reimbursement for services provided to You.

C. For Health Care Operations.
The Health Plan may also disclose Your health information for management functions. For example, the Health Plan may use and/or disclose Your health information to evaluate its performance or to conduct or arrange for legal services and audit functions, including fraud and abuse detection and compliance programs. Additionally, the Health Plan may use Your health information for its business management and general administrative activities, including but not limited to: (i) management activities relating to implementation of and compliance with law; (ii) customer service; (iii) resolution of internal grievances; (iv) the sale, transfer, merger, or consolidation of all or part of the Health Plan with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and (v) creating de-identified information or a limited data set.

D. For Treatment Alternatives.
The Health Plan may use and disclose Your health information to tell You about treatment options or alternatives that may be of interest to You.

E. For Health-Related Benefits and Services.
The Health Plan may use and disclose Your health information to tell You about health-related benefits or services that may be of interest to You.

F. To Family Members, Relatives or Close Friends.
Unless You object to such disclosure, the Health Plan may disclose Your health information to Your family members, relatives or close personal friends, or any other person identified by You as being involved in Your treatment or payment for Your medical care. If You are not present to agree or object to the Health Plan's disclosure of Your health information to a family member, relative or friend, the Health Plan may exercise its professional judgment to determine whether the disclosure is in Your best interest. If the Health Plan decides to disclose Your health information to Your family member, relative or other individual identified by You, the Health Plan will only disclose the health information that is relevant to Your treatment or payment.

G. To Business Associates.
The Health Plan may disclose Your health information to its "business associates." Third party administrators, auditors and consultants are some examples of business associates of the Health Plan.

H. Other Permitted and Required Uses and Disclosures.
In some cases, the Health Plan may use Your health information without obtaining Your authorization and without offering You the opportunity to agree or object as follows:

- as required by law, provided however, that the use or disclosure will be made in compliance with applicable law;
- to a public health authority that is authorized by law to collect or receive such information, or to a foreign government agency that is acting in collaboration with a public health authority;
- to a health oversight agency for oversight activities authorized by law, including audits and inspections, and civil, administrative or criminal investigations, proceedings or actions;
- to a public health authority or to a government authority authorized by law to receive reports of abuse, neglect or domestic violence;
- for judicial or administrative proceedings;
- for law enforcement purposes;

- to a coroner or medical examiner to perform duties authorized by law;
- to funeral directors, consistent with applicable law, as necessary to carry out their duties;
- to organ procurement organizations or similar entities for the purpose of facilitating organ, eye or tissue donation and transplantation;
- for research purposes;
- to avert a serious threat to health or safety, so long as the disclosure is only to a person who is reasonably able to prevent or lessen such threat;
- for specialized government functions, such as the proper execution of a military mission or national security activities;
- to a correctional institution or law enforcement custodian;
- to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law that provide benefits for work-related injuries or illness without regard to fault; and
- to the Plan sponsor of the Health Plan as permitted by law.

YOUR RIGHTS AS A PARTICIPANT IN THE HEALTH PLAN

As a participant in the Health Plan, You have a number of rights associated with Your health information. The following describes Your specific rights.

A. The Right to Request a Restriction or Limit on the Use and Disclosure of Your Health Information.

You have the right to request restrictions or limits on how the Health Plan is allowed to use and/or disclose Your health information, however, the Health Plan does not have to agree to Your requested restriction or limit. If You would like to request a restriction or limit on the Health Plan's use or disclosure of Your health information, please send Your written request to the address listed at the end of this Privacy Notice. Your request must specify: (1) if You would like to restrict or limit Health Plan's use, disclosure or both; (2) what information You would like to restrict or limit; and (3) to whom You want the limit or restriction to apply (e.g., Your spouse).

If the Health Plan agrees to a restriction or limit of Your health information, the restriction or limit will not prevent the Health Plan from disclosing Your health information as follows: (1) to You if You request access to Your health information or if You request an accounting of disclosures; (2) for purposes required or permitted by law (e.g., to comply with laws relating to workers' compensation); or (3) in the case of an emergency.

If the Health Plan accepts Your restriction or limit regarding how the Health Plan may use or disclose Your health information, the Health Plan may nevertheless disclose the restricted health information to a health care Provider if You are in need of emergency care and Your restricted health information is needed to provide emergency treatment to You. Before the Health Plan discloses Your restricted health information to a health care Provider during an emergency, the Health Plan will require the health care Provider that receives Your health information to not further use or disclose Your health information.

If the Health Plan accepts Your requested restriction or limit, it may terminate the restriction or limit if: (1) You agree to the termination or request the termination in writing; (2) You orally agree to the termination and the oral agreement is appropriately documented; or (3) it informs You that it is terminating the restriction or limit; provided, however, the Health Plan's termination would only be effective for health information the Health Plan creates or receives after it informs You of the termination.

B. Right to Request Confidential Communications via Alternative Means or Locations.

You have the right to request receipt of health information from the Health Plan by alternative means or via alternative locations provided that You clearly state that the disclosure of all or part of Your health information could endanger You. For example, You may want to receive communications related to Your health care at a different address other than Your home address because You could be in danger of harm if someone at that address saw Your health information. If You wish to receive confidential communications via alternative means or locations, please submit Your written request to the address listed at the end of this Privacy Notice and set forth the alternative means by which You wish to receive communications or the alternative location at which You wish to receive such communications.

C. Right to Inspect and Copy Your Health Information.

You have the right to inspect and obtain a copy of Your health information; provided, however, You are not entitled to access health information that is: (1) contained in psychotherapy notes; (2) compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or (3) is either subject to the Clinical Laboratory Improvements Amendments of 1988 ("CLIA") to the extent Your access is prohibited by law, or is exempt from CLIA. If You would like to access Your health

information, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. If You request a copy of Your health information, You will receive a response to Your request in a timely fashion but may be charged a reasonable, cost-based fee to cover copy costs and postage.

In some limited circumstances, the Health Plan may deny Your request for access to health information. For example, the Health Plan may deny access to health information that is subject to the Privacy Act. The Health Plan may also deny You access to health information if such information was obtained from someone other than a health care Provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. If Your request is denied for one of these reasons, You will not have the opportunity to review the denial.

Additionally, the Health Plan may deny You access to health information if: (1) access is reasonably likely to endanger the life and physical safety of You or someone else; (2) the access requested refers to another person and Your access is reasonably likely to cause substantial harm to such other person; or (3) You are the personal representative of another individual and a health care professional determines that Your access is reasonably likely to cause substantial harm to the individual or another person. If You are denied access for one of these reasons, You are entitled to review by a health care professional, designated by the Health Plan, who was not involved in the decision to deny access. If access is ultimately denied, You will be entitled to written explanation of the reasons for the denial.

D. Right to Receive an Accounting of Disclosures.

You have the right to receive an accounting of disclosures of Your health information made by the Health Plan, including disclosures to or by business associates of the Health Plan, for the period of six years prior to the date on which You request an accounting of disclosures, or such lesser period as You indicate; provided, however, You are not entitled to receive an accounting of disclosures for disclosures that occurred prior to April 14, 2004. If You would like to receive an accounting of disclosures, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when it receives Your request. You will receive a response to Your request for an accounting of disclosures no later than sixty days after Your request is received.

Notwithstanding the foregoing, Your accounting of disclosures will not include any disclosures made: (1) to carry out treatment, payment and/or health care operations; (2) directly to You; (3) incident to a use or disclosure permitted by law; (4) pursuant to Your authorization; (5) to persons involved in Your care; (6) for national security or intelligence purposes as permitted by law; (7) to correctional institutions or law enforcement officials as permitted by law; (8) as part of a limited data set in accordance with law; or (9) that occurred prior to April 14, 2004.

To the extent the Health Plan uses or maintains Electronic Health Records (EHRs), the Health Plan must be able to account for uses and disclosures of that information, even for treatment, payment and/or health care operations purposes. This detail must be retained for a period of at least three years. You have a right to obtain a copy of the record in an electronic format and to direct the Health Plan to transmit a copy of the record to any entity or person designated by You. This provision is effective January 1, 2011 or the date EHR is acquired for all EHRs acquired after January 1, 2009. For EHRs acquired on or before January 1, 2009, the provision will be effective January 1, 2014.

You will receive one request annually free of charge and, thereafter, the Health Plan may charge You a reasonable, cost-based fee for each subsequent request for an accounting of disclosures within the same twelve-month period. The Health Plan will notify You of the cost for an accounting of disclosures and You may choose to withdraw or modify Your request before it charges You for any costs.

E. Right to Amend Your Health Information.

If You believe the Health Plan has health information about You that is incorrect or incomplete, You may make a written request to the Health Plan stating the reasons to support Your requested amendment. You have the right to request an amendment to Your health information for so long as the Health Plan maintains Your health information. If You would like to amend Your health information, please send Your written request to the address listed at the end of this Privacy Notice. If the Health Plan does not have Your health information in its possession, it will provide You with the appropriate contact information when Your request is received. You will receive a response to Your request for an amendment no later than sixty days after the Health Plan receives Your request. However, the Health Plan may deny Your request for amendment if, for example, the

Health Plan determines that it did not create Your health information or Your health information is already accurate and complete. You may respond to a denial by the Health Plan by filing a written statement of disagreement, but the Health Plan has the right to rebut Your disagreement. If this occurs, You have the right to request that Your original request, the Health Plan's denial, Your statement of disagreement, and the Health Plan's rebuttal be included in future disclosures of Your health information.

F. Right to Receive a Paper Copy of Your Privacy Notice.
You have the right at any time to obtain a paper copy of this Privacy Notice, even if You receive this Privacy Notice electronically. If You have received an electronic copy of this Privacy Notice, but would like to obtain a paper copy of this Privacy Notice, please send Your written request to the address listed at the end of this Privacy Notice.

MISCELLANEOUS

A. Complaints.
If You believe Your privacy rights have been violated, You may file a complaint through Customer Service by calling the number on the ID card.

You can also file a complaint with the Tennessee Department of Insurance; however, such complaints are separate from and in addition to, the Appeals processes in this EOC.

If You would like to file a complaint with the Health Plan, please forward Your written complaint to the address listed at the end of this Privacy Notice. If You choose to file a complaint, the Health Plan is prohibited by law from retaliating against You for filing such complaint.

B. Breach.
The Covered Entity is required to notify each individual whose unsecured protected health information is the subject of a breach, or is reasonably believed to be subject of a breach. Notification must occur within 60 days of the discovery of the breach. In addition, the Health Plan must notify the Secretary of the Department of Health and Human Services. If the breach involves 500 or more individuals, the Covered Entity is also required to notify a local media outlet serving the state or jurisdiction in which the individuals reside.

This provision is effective 180 days after the enactment date. The enactment date is February 17, 2009.

C. Effective Date.
This revised notice is effective as of January 1, 2014.

D. Contact Information.
If You need any additional information about this Privacy Notice, please contact, the Privacy Officer, Community Health Alliance
445 South Gay St.
Knoxville, TN 37902.

GENETIC INFORMATION

The Plan operates in compliance with the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) ("GINA"), which prohibits group health Plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, You are entitled to certain rights and protections under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). Because the HSAs are not welfare benefit Plans subject to ERISA, these rights and protections do not apply to the HSAs. Except with respect to Your HSA, You have the right to:

- examine, without charge, at the Plan s office and at other specified locations, all Plan documents, including insurance contracts and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- obtain copies of all Plan documents and other Plan information upon written request to the Plan. The Plan may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant in a funded Plan with a copy of this summary annual report.
- continue health care coverage for Yourself, Your spouse or Your Dependents if there is a loss of coverage under a health benefit Plan as a result of a qualifying event. You or Your Dependents may have to pay for such

coverage. Review this summary Plan description and the documents governing the Plan for the rules governing Your COBRA continuation rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plans. The people who operate Your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or discriminate against You in any way in order to prevent You from obtaining a benefit to which You are entitled, or from exercising Your rights under ERISA.

If Your claim for a benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial, and You have the right to have the Plan review and reconsider Your claim (see section entitled, *Appealing a Claim*). Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive them, unless the materials were not sent because of reasons beyond the control of the Administrator.

If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a federal or state court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, You may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the Plan, You should contact Your employer through Your local Human Resources representative. If You are not satisfied with the answers to Your questions, or if You have questions about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

PLAN CHANGES AND TERMINATION

The Plan reserves the right to terminate, suspend, withdraw, amend, or modify the Plan, any portion of the Plan, and this EOC, in whole or in part, at any time and for any reason, and to change administrators and service providers for the Plan, in its sole discretion. The Plan does not promise the continuation of any benefit, nor does it promise any specific level of benefits, or cost for such benefits.

No one has the authority to make any oral modifications to the Plan or this EOC.

GENERAL RESTRICTIONS AGAINST ALIENATION

You may not sell, assign or transfer Your interest in the Plan, except to the extent that the Plan permits assignments of Your benefits to health care providers. The Plan can, however, disburse funds to Your legally appointed guardian, executor, administrator or personal representative. If You declare bankruptcy or anticipate, sell, transfer, assign or encumber a Plan distribution or payment, voluntarily or involuntarily, Your benefit payments can be restricted.

NO EMPLOYMENT RIGHTS

Neither the adoption of the Plan, nor Your status as a Participant in any underlying Plan shall constitute a guarantee of continued employment with the employer. Also, You cannot sell, transfer or assign either voluntarily or involuntarily the value of Your benefit under the Plans.

TAX EFFECT

Neither the Plan nor the Plan Sponsor makes any warranty or other representation as to whether any payments or benefits You receive from the Plan will be treated as includable in gross income for federal or state income tax purposes.

PLAN ADMINISTRATION AND INTERPRETATION

The Plan shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. The Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan

member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

CLAIMS ADMINISTRATOR

The Plan has retained HealthSCOPE Benefits, Inc. to administer and process claims for benefits according to the Plan and consistent with a framework of rules, policies, interpretations, practices and procedures adopted by the Plan.

NAME OF PLAN

The Community Health Alliance Group Benefit Plan.

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ISSUER

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

The Plan Sponsor retains all fiduciary responsibility with respect to the Plan except to the extent the Plan Sponsor has delegated such responsibilities to other persons or entities.

EFFECTIVE DATE OF THIS EOC

January 1, 2014, except as noted in this EOC.

NAME, BUSINESS ADDRESS, AND BUSINESS TELEPHONE NUMBER OF PLAN ADMINISTRATOR

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

DATE OF THE END OF THE YEAR FOR PURPOSES OF MAINTAINING PLAN'S FISCAL RECORDS

The Plan year shall be a twelve month period ending December 31.

GOVERNING LAW

Your benefits will be governed by the laws of the State of Tennessee; however, if the extraterritorial laws of another state apply to Your benefits, Your benefits will be administered accordingly.

AGENT FOR SERVICE OF LEGAL PROCESS

Community Health Alliance
445 South Gay St.
Knoxville, TN 37902

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema.

If You are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Expenses as You determine appropriate care with Your attending Physician:

- Coverage for hospitalization following mastectomy for at least 48 hours, unless Your attending Physician determines early release is appropriate. In the case of early release, at least one home visit will be covered if ordered by Your attending Physician;
- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complication of the mastectomy, including lymphedema.

The amount You must pay for such Covered Expenses, including Plan Year Deductible, are the same as are required for any other Covered Expense. Limits on Benefits are the same as for any other Covered Expense.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health Plans and health insurance issuers generally may not, under Federal or State law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery (not including the day of delivery), or less than 96 hours following a cesarean section (not including the day of surgery). However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her coverage and coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave. Check with the Group to see if this provision applies.

KEY TERMS AND DEFINITIONS

The following terms or phrases are used throughout the EOC. These terms or phrases have special meaning.

ADVERSE DETERMINATION

Means a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed; and, based upon the information provided:

- Does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness; or
- Is Experimental or Investigational and involves a condition that is life threatening or seriously disabling.

ALLOWED AMOUNT

Means the maximum amount on which payment is based for covered expenses or covered benefits. If Your Non-Network Provider charges more than the Allowed Amount, You may have to pay the difference.

APPEAL

Means a request for the Plan to review a decision again.

AUTHORIZED REPRESENTATIVE

Means:

- A person to whom a covered person has given express written consent to represent the covered person in an external review;
- A person authorized by law to provide substituted consent for a covered person; or
- A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent.

AUTISM SPECTRUM DISORDERS

Means neurological disorders, usually appearing in the first 3 years of a person's life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

BALANCE BILLING

When a Provider bills You for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is $100 and the Allowed Amount is $70, the Provider may bill You for the remaining $30. A Network Provider should not balance bill You for Covered Services. Contact Customer Service if You have questions about how much You may owe.

BIRTHING CENTER

Means an inpatient or outpatient facility which:

- complies with all legal requirements in the jurisdiction where it is located;
- primarily provides a comprehensive Birth Services program to pregnant individuals who are considered normal low risk patients;
- has organized facilities for Birth Services on its premises;
- has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a nurse midwife; and
- has 24-hour-a-day Registered Nurse Services.

BIRTH SERVICES

Means antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor; and 2) spontaneous vaginal delivery.

CLINICAL REVIEW CRITERIA

Means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

COINSURANCE

Means Your share of the costs of a Covered Service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. You pay coinsurance plus any Deductibles You owe. For example, if the Plan's Allowed Amount for an office visit is $100 and You've met Your Deductible, Your coinsurance payment of 20% would be $20. The Plan pays the rest of the Allowed Amount.

COMPLICATIONS OF PREGNANCY

Means a condition due to pregnancy, labor and delivery that requires medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section aren't complications of pregnancy.

COPAYMENT

Means a fixed amount (for example, $15) You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

COVERED EXPENSE OR COVERED BENEFIT OR COVERED SERVICE

Means the expenses as defined and listed on the section entitled, *What's Covered under the Health Coverage Plan*.

COVERED DEPENDENT

Means an Eligible Dependent whose coverage under the Plan: 1) became effective; and 2) has not terminated.

COVERED EMPLOYEE

Means an Eligible Employee whose coverage under the Plan: 1) became effective, and 2) has not terminated.

COVERED PERSON

Means an Eligible Employee and Eligible Dependent whose coverage under the Plan: 1) became effective; and 2) has not terminated.

DEDUCTIBLE

Means the amount You owe for Covered Services before the Plan begins to pay. For example, if Your Deductible is $1,000, the Plan won't pay anything until You've met Your $1,000 Deductible for Covered Services subject to the Deductible. The Deductible may not apply to all services.

DRUG

Means a substance recognized by an official pharmacopoeia or formulary; a substance intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease; a substance (other than food) intended to affect the structure or any function of the body; a substance intended for use as a component of a medicine but not a device or component, part or accessory of a device; biological products are included within this definition and are generally covered by the same laws and regulations, but differences exist regarding their manufacturing processes (chemical process versus biological process.

DURABLE MEDICAL EQUIPMENT

Means equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for Durable Medical Equipment may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

ELIGIBLE DEPENDENT

Means a Dependent who meets the eligibility requirements under the Plan. Refer to the *Dependent Eligibility* section on page 3 under *Eligibility and Enrollment* for the specific definition.

ELIGIBLE EMPLOYEE

Means an employee who meets the eligibility requirements under the Plan. Refer to the *Eligibility* section for the specific definition.

EMERGENCY CARE

Means medical and health services provided for a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL CONDITION

Means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in:

- placing the health or survival of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

EMERGENCY MEDICAL TRANSPORTATION

Means ambulance services for an Emergency Medical Condition.

EMERGENCY ROOM CARE

Means Emergency Services You get in an Emergency Room.

EMERGENCY SERVICES

Means evaluation of an Emergency Medical Condition and treatment to keep the condition from getting worse.

ESSENTIAL HEALTH BENEFITS

Means, under section 1302(b) of the Patient Protection and Affordable Care Act, as amended from this time to time, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease

management; and pediatric services, including oral and vision care.

EXCLUDED SERVICES

Means health care services the Plan doesn't pay for or cover.

EXPERIMENTAL / INVESTIGATIONAL SERVICES

Means at the time a determination is made regarding coverage in a particular case, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will be determined to be "Investigative" if reliable, authoritative evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes as compared with the standard means of treatment or diagnosis.

The Plan will base its determination upon an examination of one or more of the following kinds of reliable evidence, none of which shall be determinative in and of itself:

- Published reports, articles, or consensus expert panel opinions and recommendations in the authoritative peer reviewed medical and scientific literature
- Written protocol(s) used by the treating Provider; or the protocol(s) of another Provider studying substantially the same service; or the written informed consent used by the treating Provider or by another Provider studying substantially the same service
- Review by a financially disinterested, external, specialty appropriate board-certified expert medical reviewer

All determinations of reliable evidence shall be made by the Plan.

Notwithstanding the above, a drug, device, diagnostic or screening procedure, or a medical treatment or procedure will not be determined to be "investigative" and will be considered a covered benefit when it is being administered or performed as part of a Phase III clinical investigational trial where all treatment arms involve Covered Services for covered conditions. In addition, in the context of drugs used in the treatment of cancer, the use of a drug will not be considered Experimental and/or Investigational where: (1) the use of the drug has been recognized as safe and effective for the treatment of the specific type of cancer in the National Comprehensive Cancer Network's Drugs and Biologics Compendium, Thomson Micromedex DRUGDEX, Thomson Micromedex DrugPoints or Clinical Pharmacology, United States Pharmacopoeia Drug Information, American Medical Association Drug Evaluations, American Hospital Formulary Service Drug Information, or two articles from major peer reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; or (2) the drug is provided for a Phase III or IV trial for cancer, as approved by the FDA or sanctioned by the National Cancer Institute ("NCI") or (3) the drug is provided in for a Phase II trial for cancer by an NCI-sponsored group and standard treatment has been or would be ineffective or does not exist or there is no clearly superior non-investigational alternative that can be delivered more cost efficiently as determined by the Plan Administrator.

FACILITY

Means an institution providing health care services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

FINAL ADVERSE DETERMINATION

Means an adverse determination involving a covered benefit that has been upheld at the completion of the internal Appeal process.

GRIEVANCE

A complaint that You communicate to the Plan.

GROUP AGREEMENT OR AGREEMENT

Means the arrangements between the Plan and the Group including this EOC, the Plan Sponsor Group Application, any Riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.

GROUP OR PLAN SPONSOR

Means a corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide coverage to its employees and their Eligible Dependents.

HABILITATION SERVICES

Means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HEALTH INSURANCE

Means a contract that requires Your health insurer to pay some or all of Your health care costs in exchange for a Premium.

HEALTH INSURANCE COVERAGE

Means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service Plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

- Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Credit only insurance;
- Coverage for on site medical clinics;
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
- If offered separately: limited scope dental or vision benefits, benefits for long term care, nursing home care, home health care, community based care, or any combination of these, or other similar, limited benefits as are specified in regulations;
- If offered as independent, noncoordinated benefits;
- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance;
  If offered as a separate insurance policy: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code, and similar supplemental coverage under a group health Plan.

HOME HEALTH CARE

Means health care services a person receives at home.

HOME HEALTH CARE AGENCY

Means a public or private agency that provides skilled nursing functions or activities in the Covered Person's home. It is licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

HOSPITAL

Means an institution which:

- is legally operated in the jurisdiction where it is located;
- is engaged mainly in providing inpatient medical care and treatment for Injury and Illness/Sickness in return for compensation;
- has organized facilities for diagnosis and major surgery on its premises;
- is supervised by a staff of at least two Physicians;
- has 24-hour-a-day nursing service by Registered Nurses; and
- is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or Skilled Nursing Facility or similar institution; or a Long Term Acute Care Facility (LTAC).

HOSPICE SERVICES

Means services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITALIZATION

Means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

HOSPITAL OUTPATIENT CARE

Means care in a Hospital that doesn't require an overnight stay.

ILLNESS

Means a sickness or a disease of a Covered Employee or Covered Dependent. Illness will include congenital defects or birth abnormalities.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of

Adverse Determinations and final Adverse Determinations.

IN-NETWORK COINSURANCE

Means the percent (for example, 20%) You pay of the Allowed Amount for Covered Services to Providers who contract with Your Plan.

IN-NETWORK COPAYMENT

Means a fixed amount (for example, $15) You pay for Covered Services to Providers who contract with Your Plan.

INJURY

Means accidental bodily injury of a Covered Employee or Covered Dependent.

INTENSIVE CARE UNIT

Means a section, ward or wing within the Hospital which:

- is separated from other Hospital facilities;
- is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
- has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
- provides room and board; and
- provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

LICENSED PRACTICAL NURSE

Means an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service. This definition will include licensed vocational nurses with the above qualifications.

LIFE THREATENING CONDITION OR DISEASE

Means a condition or disease which, according to the current diagnosis by the Covered Person's treating Physician, has a high probability of causing the Covered Person's death.

MAXIMUM OUT OF POCKET (MOOP)

Means the most You pay during a policy period (usually a year) before the Plan begins to pay 100% of the Allowed Amount. This limit never includes Your Premiums, balance-billed charges or health care Your Plan doesn't cover.

MEDICAL AND SCIENTIFIC EVIDENCE

Means:

- peer reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research;
- medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;
- these standard reference compendia: the American Hospital Formulary Service Drug Information, the American Medical Association Drug Evaluation the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia Drug Information;
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

MEDICALLY NECESSARY

Means health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

MEMBER, YOU, YOUR

Means any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.

NETWORK

Means the facilities, providers and suppliers Your Plan has contracted with to provide health care services.

NETWORK PROVIDER

Means a participating Provider that the Preferred Provider network or

one of its rental networks have contracted with or made arrangements with to provide health services to Covered Persons. A Network Provider has agreed to charge participants a discounted rate. To determine if a Provider is a Network Provider log onto www.chatn.org and click the *Find a Provider* tab. You may also call the number on Your ID card and a Customer Service representative can locate a Network Provider for You. A provider list based on Your zip code will be sent to You, free of charge, upon Your request.

The term Provider means a Physician, eligible professional provider, Hospital and eligible health care facility provider.

OUT-OF-NETWORK PROVIDER

An Out-of-Network Provider is a Provider not under contract as a Network Provider either with the Covered Person's PPO network or a reciprocal network. No benefits or payments are available for services received from and Out of Network Provider, even if the services would otherwise be deemed Covered Services, except in the case of a true Emergency.

PHYSICIAN

Means a person who has successfully completed the prescribed course of studies in medicine in a medical school officially recognized and who has acquired the requisite qualifications for license in the state in which the treatment is received in the practice of medicine. He or she must be practicing within the scope of that license.

PHYSICIAN SERVICES

Means health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

PLAN

Means a benefit Your employer, union, or other group sponsor provides to You to pay for Your health care services.

PLAN YEAR

Means a 12-month period of time that follows the Plan's Effective Date and each subsequent twelve-month period this Plan remains in force.

PRACTITIONER

A professional who provides health care services. Practitioners are usually licensed as required by law.

PREAUTHORIZATION

Means a decision by Your Plan that a health care service, treatment Plan, prescription drug, or durable medical equipment is Medically Necessary. Sometimes called prior authorization, prior approval or precertification. Your Plan may require preauthorization for certain services before You receive them, except in an emergency. Preauthorization isn't a promise Your Plan will cover the cost.

PREFERRED PROVIDER

Means a Provider who has a contract with Your Plan to provide services to You at a discount. Check the Plan to see if You can see all Preferred Providers or if Your Plan has a "tiered" network and You must pay extra to see some providers. Your Plan may have Preferred Providers who are also "participating" Providers. Participating Providers also contract with Your Plan, but the discount may not be as great, and You may have to pay more.

PREMIUM

Means the amount that must be paid for Your Plan. You and/or Your Plan Sponsor usually pay it monthly, quarterly or yearly.

PRESCRIPTION DRUG

Means a drug that can be dispensed to the public only with an order given by a properly authorized person. The designation of a medication as a prescription drug is made by the U.S. Food and Drug Administration.

PRESCRIPTION DRUG COVERAGE

Means Health Insurance or Plan that helps pay for Prescription Drugs and medications.

PRESCRIPTION DRUG PRODUCT

A prescription drug product requires a doctor's authorization to purchase.

PRIMARY CARE PHYSICIAN

Means a Physician, including a Pediatrician and OB/GYN (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

PRIMARY CARE PROVIDERS

Means a Physician, including a Pediatrician and OB/GYN (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

PROVIDER

Means a Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

QMCSOs are state court orders requiring a parent to provide

medical support to a child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to Your child even though, for income tax or Plan purposes, the child is not Your Dependent. To qualify, a QMCSO must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which:

- specifies Your last known name and address and the child's last known name and address,
- describes the type of coverage to be provided, or how the type of coverage will be determined,
- states the period to which it applies, and
- specifies each Plan to which it applies.
- The QMCSO cannot require the Plans to cover any type or form of benefit that they do not currently cover. The Plans must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions.
- You and the affected child will be notified if an order is received and will be provided, free of charge, with a copy of Your Plan Sponsor's QMCSO procedures.

RECONSTRUCTIVE SURGERY

Means surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

REGISTERED NURSE

Means a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided.

REHABILITATION SERVICES

Means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

REIMBURSABLE PAYMENTS

Means payments made by this Plan for health care benefits that are or become the responsibility of another party under the subrogation provisions of this EOC.

SERIOUS MEDICAL CONDITION

Means a health condition of illness that requires immediate medical attention where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SERIOUSLY DISABLING

Means a health condition or illness that involves a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

SKILLED NURSING CARE

Means services from licensed nurses in Your own home or in a nursing home. Skilled care services are from technicians and therapists in Your home or in a nursing home.

SPECIALIST

Means a physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician Specialist is a Provider who has more training in a specific area of health care.

SUBSCRIBER

Means an Employee who meets all applicable eligibility requirements, has enrolled or coverage and for whom the Plan has received the applicable Premium for coverage from the Group.

URGENT CARE CENTER

Means a facility operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

USUAL AND CUSTOMARY

Means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The Usual and Customary amount as determined at the sole discretion of the Health Plan sometimes is used to determine the Allowed Amount.

The Plan covers Covered Expenses up to the Usual and Customary amount when an Out-of-Network Provider is used.

URGENT CARE

Means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes to the Plan. Generally, Plan changes are announced each year in the fall during Annual Enrollment.

	In-Network	**Out-of-Network**
Deductibles		
Employee		
Family		
Plan Year Out-of-Pocket Maximum (Excludes Deductible)		
Employee		
Family		
Maximum Benefit Limit Per Covered Individual for:		
Transplants		

	In-Network	Out-of-Network
Accidental Dental Care		
Acupuncture		
Ambulance		
Asthma		
Chiropractic Care		
Contraceptive Services		
CT, MRI and PET scan		
Durable Medical Equipment		
Emergency Room		
Home Healthcare		
Home Infusion Therapy		
Hospice Care		
Infertility		
Inpatient Hospital Care		
Inpatient Rehabilitations		
Lab and X-Ray		
Maternity Care		
Medical Supplies		
Mental Health Inpatient & Outpatient Services		
Nutritionist		
Occupational Therapy		
Office Visits		
Oral Surgery		
Outpatient Hospital Care		
Physical Therapy		
Physician Services		
Preventive Care Services		

Prescription Drugs		
Retail		
Mail Order or from a retail pharmacy		
Radiation Therapy Chemotherapy		
Skilled Nursing Facility		
Speech Therapy		
Substance Abuse Inpatient & Outpatient Care		
TMJ		
Transplants		
Urgent Care		
All Other Covered Expenses		

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$4,000	$8,000
Family	$8,000	$16,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted	40% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	40% Coinsurance after Deductible
Well Woman Exam	$0 Copay	40% Coinsurance after Deductible
Screening Mammogram	$0 Copay	40% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	40% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	40% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	40% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$20 Copay	40% Coinsurance after Deductible
Specialist Office Visit	$45 Copay	40% Coinsurance after Deductible
Other Practitioner	$20 Copay	40% Coinsurance after Deductible
Prenatal and Postnatal Care	$20 Copay	40% Coinsurance after Deductible
Family Planning and Reproductive Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chiropractic Care	$20 Copay	40% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	$0 Copay	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$45 Copay	40% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Inpatient Physician and Surgical Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay	$50 Copay
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
X-rays and Diagnostic Imaging	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Home Health Care Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	
Emergency Room Services	$100 Copay and 20% Coinsurance	40% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Rehabilitative Speech Therapy	20% Coinsurance	40% Coinsurance
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance	40% Coinsurance
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay	
	Preferred Brand Drugs - $25 Copay	
	Non-Preferred Brand Drugs - $55 Copay	
	Specialty Drugs – 20% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order	
	Preferred Brand Drugs - $75 Copay, Retail; $50 Copay, Mail Order	
	Non-Preferred Brand Drugs - $165 Copay, Retail; $110, Mail Order	
	Specialty Drugs – 20% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$4,000	$8,000
Family	$8,000	$16,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted	50% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	50% Coinsurance after Deductible
Well Woman Exam	$0 Copay	50% Coinsurance after Deductible
Screening Mammogram	$0 Copay	50% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	50% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$20 Copay	50% Coinsurance after Deductible
Specialist Office Visit	$50 Copay	50% Coinsurance after Deductible
Other Practitioner	$20 Copay	50% Coinsurance after Deductible
Prenatal and Postnatal Care	$20 Copay	50% Coinsurance after Deductible
Family Planning and Reproductive Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Care	$20 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	$0 Copay	50% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information	50% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay	50% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-rays and Diagnostic Imaging	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	

Emergency Room Services	$100 Copay and 30% Coinsurance	50% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitative Speech Therapy	30% Coinsurance	50% Coinsurance
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance	50% Coinsurance
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay	
	Preferred Brand Drugs - $30 Copay	
	Non-Preferred Brand Drugs - $60 Copay	
	Specialty Drugs – 30% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order	
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order	
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order	
	Specialty Drugs – 30% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$1,000	$2,000
Family	$2,000	$4,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$4,500	$9,000
Family	$9,000	$18,000
Coinsurance	30% of the Allowed Amount, unless otherwise noted	50% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	50% Coinsurance after Deductible
Well Woman Exam	$0 Copay	50% Coinsurance after Deductible
Screening Mammogram	$0 Copay	50% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	50% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$20 Copay	50% Coinsurance after Deductible
Specialist Office Visit	$50 Copay	50% Coinsurance after Deductible
Other Practitioner	$20 Copay	50% Coinsurance after Deductible
Prenatal and Postnatal Care	$20 Copay	50% Coinsurance after Deductible
Family Planning and Reproductive Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Care	$20 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	$0 Copay	50% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information	50% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay	50% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-rays and Diagnostic Imaging	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	
Emergency Room Services	$100 Copay and 30% Coinsurance	50% Coinsurance after Deductible

Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitative Speech Therapy	30% Coinsurance	50% Coinsurance
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance	50% Coinsurance
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay	
	Preferred Brand Drugs - $30 Copay	
	Non-Preferred Brand Drugs - $60 Copay	
	Specialty Drugs – 30% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order	
	Preferred Brand Drugs - $90 Copay, Retail; $60 Copay, Mail Order	
	Non-Preferred Brand Drugs - $180 Copay, Retail; $120, Mail Order	
	Specialty Drugs – 30% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$6,350	$12,800
Family	$12,800	$25,600
Coinsurance	30% of the Allowed Amount, unless otherwise noted	50% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network**	**Out-of-Network**
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	50% Coinsurance after Deductible
Well Woman Exam	$0 Copay	50% Coinsurance after Deductible
Screening Mammogram	$0 Copay	50% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	50% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$25 Copay	50% Coinsurance after Deductible
Specialist Office Visit	$50 Copay	50% Coinsurance after Deductible
Other Practitioner	$25 Copay	50% Coinsurance after Deductible
Prenatal and Postnatal Care	$25 Copay	50% Coinsurance after Deductible
Family Planning and Reproductive Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Care	$25 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	$0 Copay	50% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information	50% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$50 Copay	50% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Urgent Care Centers or Facilities	$50 Copay	$50 Copay
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-rays and Diagnostic Imaging	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	
Emergency Room Services	$150 Copay and 30% Coinsurance	$150 Copay and 50% Coinsurance

Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitative Speech Therapy	$50 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	$50 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay	
	Preferred Brand Drugs - $40 Copay	
	Non-Preferred Brand Drugs - $75 Copay	
	Specialty Drugs – 30% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order	
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order	
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order	
	Specialty Drugs – 30% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$6,350	$12,800
Family	$12,800	$25,600
Coinsurance	40% of the Allowed Amount, unless otherwise noted	60% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network**	**Out-of-Network**
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	60% Coinsurance after Deductible
Well Woman Exam	$0 Copay	60% Coinsurance after Deductible
Screening Mammogram	$0 Copay	60% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	60% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	60% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	60% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$35 Copay	60% Coinsurance after Deductible
Specialist Office Visit	$65 Copay	60% Coinsurance after Deductible
Other Practitioner	$35 Copay	60% Coinsurance after Deductible
Prenatal and Postnatal Care	$35 Copay	60% Coinsurance after Deductible
Family Planning and Reproductive Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Chiropractic Care	$35 Copay	60% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	$0 Copay	60% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Diabetic Care Management	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Dental Anesthesia	40% Coinsurance after Deductible See the Dental Services section for additional information	60% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	$65 Copay	60% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Hospice Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Inpatient Physician and Surgical Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible

Skilled Nursing Facility	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Urgent Care Centers or Facilities	$65 Copay	$65 Copay
Delivery and All Inpatient Services for Maternity Care	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Reconstructive Surgery	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	40% Coinsurance after Deductible	60% Coinsurance after Deductible
X-rays and Diagnostic Imaging	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Home Health Care Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	
Emergency Room Services	$150 Copay and 40% Coinsurance	$150 Copay and 60% Coinsurance

Durable Medical Equipment	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Hearing Aids	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Rehabilitative Speech Therapy	$65 Copay	60% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	$65 Copay	60% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Clinical Trials	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $10 Copay	
	Preferred Brand Drugs - $40 Copay	
	Non-Preferred Brand Drugs - $75 Copay	
	Specialty Drugs – 40% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $30 Copay, Retail; $20 Copay, Mail Order	
	Preferred Brand Drugs - $120 Copay, Retail; $80 Copay, Mail Order	
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order	
	Specialty Drugs – 40% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	40% Coinsurance after Deductible	60% Coinsurance after Deductible
Transplants	40% Coinsurance after Deductible	60% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

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	In-Network	Out-of-Network
Deductibles		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$6,350	$12,800
Family	$12,800	$25,600
Coinsurance	30% of the Allowed Amount, unless otherwise noted	50% of the Allowed Amount, unless otherwise noted

Covered Services	**In-Network**	**Out-of-Network**
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	50% Coinsurance after Deductible
Well Woman Exam	$0 Copay	50% Coinsurance after Deductible
Screening Mammogram	$0 Copay	50% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	50% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay	50% Coinsurance after Deductible
	Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	$35 Copay	50% Coinsurance after Deductible
Specialist Office Visit	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Practitioner	$35 Copay	50% Coinsurance after Deductible
Prenatal and Postnatal Care	$35 Copay	50% Coinsurance after Deductible
Family Planning and Reproductive Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Chiropractic Care	$35 Copay	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diabetic Care Management	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Anesthesia	30% Coinsurance after Deductible See the Dental Services section for additional information	50% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Skilled Nursing Facility	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Urgent Care Centers or Facilities	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Reconstructive Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-rays and Diagnostic Imaging	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Health Care Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	
Emergency Room Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hearing Aids	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitative Speech Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Clinical Trials	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $15 Copay	
	Preferred Brand Drugs - $45 Copay	
	Non-Preferred Brand Drugs - $75 Copay	
	Specialty Drugs – 30% Coinsurance	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - $45 Copay, Retail; $30 Copay, Mail Order	
	Preferred Brand Drugs - $135 Copay, Retail; $90 Copay, Mail Order	
	Non-Preferred Brand Drugs - $225 Copay, Retail; $150, Mail Order	
	Specialty Drugs – 30% Coinsurance	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Transplants	30% Coinsurance after Deductible	50% Coinsurance after Deductible
	Pre-certification required	

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Deductibles		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$2,000	$6,000
Family	$4,000	$12,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted	30% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	30% Coinsurance after Deductible
Well Woman Exam	$0 Copay	30% Coinsurance after Deductible
Screening Mammogram	$0 Copay	30% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	30% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay Limit of one exam per calendar year	30% Coinsurance after Deductible Limit of one exam per calendar year

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	30% Coinsurance after Deductible Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible 6 Months per Episode	30% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Inpatient Physician and Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Skilled Nursing Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	

Emergency Room Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Rehabilitative Speech Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible Limit of 20 Visits per Calendar Year	30% Coinsurance after Deductible Limit of 20 Visits per Calendar Year
Prosthetic Devices	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible	
	Preferred Brand Drugs - 0% Coinsurance after Deductible	
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible	
	Specialty Drugs – 0% Coinsurance after Deductible	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Preferred Brand Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Specialty Drugs – 0% Coinsurance after Deductible, Retail and Mail Order	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. To receive benefits under the Plan, You must see a Network Provider. If you see an out of network or non-network provider, no benefits will be available except in the case of a true Emergency.

	In-Network	Out-of-Network
Deductibles		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$6,000	$12,000
Family	$12,000	$24,000
Coinsurance	20% of the Allowed Amount, unless otherwise noted	40% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	40% Coinsurance after Deductible
Well Woman Exam	$0 Copay	40% Coinsurance after Deductible
Screening Mammogram	$0 Copay	40% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	40% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	40% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	40% Coinsurance after Deductible Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Specialist Office Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Practitioner	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prenatal and Postnatal Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Family Planning and Reproductive Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chiropractic Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Care Management	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dental Anesthesia	20% Coinsurance after Deductible See the Dental Services section for additional information	40% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Services	20% Coinsurance after Deductible 6 Months per Episode	40% Coinsurance after Deductible 6 Months per Episode
Inpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Inpatient Physician and Surgical Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of one exam per calendar year	
Habilitation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Centers or Facilities	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Reconstructive Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
X-rays and Diagnostic Imaging	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	

Emergency Room Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Aids	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Rehabilitative Speech Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Clinical Trials	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 20% Coinsurance after Deductible	
	Preferred Brand Drugs - 20% Coinsurance after Deductible	
	Non-Preferred Brand Drugs - 20% Coinsurance after Deductible	
	Specialty Drugs – 20% Coinsurance after Deductible	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 20% Coinsurance after Deductible, Retail and Mail Order	
	Preferred Brand Drugs - 20% Coinsurance after Deductible, Retail and Mail Order	
	Non-Preferred Brand Drugs - 20% Coinsurance after Deductible, Retail and Mail Order	
	Specialty Drugs – 20% Coinsurance after Deductible, Retail and Mail Order	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Transplants	20% Coinsurance after Deductible	40% Coinsurance after Deductible
	Pre-certification required	

EXHIBIT A: SCHEDULE OF BENEFITS

The values listed in this table are those in effect as of January 1, 2014. The Plan reserves the right to make changes. Generally, Plan changes are announced each year during Annual Enrollment. If you see an out of network or non-network provider, benefits may be reduced.

	In-Network	Out-of-Network
Deductibles		
Individual	$5,500	$8,000
Family	$11,000	$16,000
Out-of-Pocket Maximum	Expenses incurred by all family members will be used to satisfy the Family Out-of-Pocket Maximum.	
Individual	$5,500	$12,000
Family	$11,000	$24,000
Coinsurance	0% of the Allowed Amount, unless otherwise noted	30% of the Allowed Amount, unless otherwise noted

Covered Services	In-Network	Out-of-Network
	All coinsurance shown after Deductible unless otherwise specified Member Pays:	
Services Received at a Practitioner's Office		
Office Services for Preventive Care		
Preventive Care/ Screening/ Immunization	$0 Copay	30% Coinsurance after Deductible
Well Woman Exam	$0 Copay	30% Coinsurance after Deductible
Screening Mammogram	$0 Copay	30% Coinsurance after Deductible
Prostate Cancer Screening	$0 Copay	30% Coinsurance after Deductible
Routine Eye Exam for Children	$0 Copay	30% Coinsurance after Deductible
	Limit of one exam per calendar year	

Eye Glasses for Children	$0 Copay Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses	30% Coinsurance after Deductible Limit of one routine eye examination per calendar year Limit of one frame per calendar year Limit of one pair of standard eyeglass lenses or contact lenses every calendar year $150 Maximum Allowance for Frames and Contact Lenses
Office Services for Diagnosis and Treatment of Illness or Injury		
Primary Care Office Visit	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Specialist Office Visit	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Practitioner	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Prenatal and Postnatal Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Family Planning and Reproductive Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Chiropractic Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Lab and X-Ray in Office	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Treatment for Temporomandibular Joint Disorders	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Diabetic Care Management	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Inherited Metabolic Disorder - PKU	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Dental Anesthesia	0% Coinsurance after Deductible See the Dental Services section for additional information	30% Coinsurance after Deductible See the Dental Services section for additional information
Routine Foot Care (covered only for diabetics)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Services Received at a Facility		
Outpatient Facility Fee	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	6 Months per Episode	
Inpatient Hospital Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible

Inpatient Physician and Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Skilled Nursing Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 60 Days per Benefit Period	
Outpatient Rehabilitation Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Habilitation Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Urgent Care Centers or Facilities	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Delivery and All Inpatient Services for Maternity Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental/Behavioral Health Outpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Mental/Behavioral Health Inpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Reconstructive Surgery	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Congenital Anomaly, including Cleft Lip/Palate	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	0% Coinsurance after Deductible	30% Coinsurance after Deductible
X-rays and Diagnostic Imaging	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Laboratory Outpatient and Professional Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Other Services		
Emergency Transport/Ambulance	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Non-Emergency Care When Traveling Outside the U. S.	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Care Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 60 Visits per Benefit Period	

Emergency Room Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Aids	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Rehabilitative Speech Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Rehabilitative Occupational and Rehabilitative Physical Therapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Limit of 20 Visits per Calendar Year	
Prosthetic Devices	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Clinical Trials	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Prescription Drugs 30 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible	
	Preferred Brand Drugs - 0% Coinsurance after Deductible	
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible	
	Specialty Drugs – 0% Coinsurance after Deductible	
	Immunizations - $0 Copay	
	Note: Certain drugs require limitations. See the Formulary for details.	
Prescription Drugs 90 Day Supply (Quantity Limits may apply – see Formulary)	Generic Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Preferred Brand Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Non-Preferred Brand Drugs - 0% Coinsurance after Deductible, Retail and Mail Order	
	Specialty Drugs – 0% Coinsurance after Deductible, Retail and Mail Order	
	Note: Certain drugs have limitations. See the Formulary for details.	
Off Label Prescription Drugs	Copay for applicable tier	
Mandated Drugs	$0 Copay	$0 Copay
Dental Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Note: Limited to certain procedures as described in the Evidence of Coverage.	
Radiation Therapy Chemotherapy	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Transplants	0% Coinsurance after Deductible	30% Coinsurance after Deductible
	Pre-certification required	